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# NEW JERSEY REGISTER

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*THE JOURNAL OF STATE AGENCY RULEMAKING*

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**(Includes adopted rules filed through July 26, 1993)**

**MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: JUNE 21, 1993**
**See the Register Index for Subsequent Rulemaking Activity.**

**NEXT UPDATE: SUPPLEMENT JULY 19, 1993**

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# INTERESTED PERSONS

**Interested persons** may submit comments, information or arguments concerning any of the rule proposals in this issue until **September 15, 1993.** Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal.

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

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

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## NEW JERSEY REGISTER

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# RULE PROPOSALS

## AGRICULTURE

### (a)

### DIVISION OF REGULATORY SERVICES

### New Jersey Commercial Fertilizer and Soil Conditioners

### Plant Food Nutrient Values

### Proposed Amendment: N.J.A.C. 2:69-1.11

Authorized By: State Board of Agriculture and Arthur R. Brown, Jr., Secretary, Department of Agriculture.

Authority: N.J.S.A. 4:9-15.26.

Proposal Number: PRN 1993-435.

Submit comments by September 15, 1993 to:
Dhun B. Patel, Ph.D., Director
Division of Regulatory Services
N.J. Department of Agriculture
CN 330
Trenton, New Jersey 08625
Telephone: (609) 292-5575

The agency proposal follows:

**Summary**

The purpose of this proposal is to update the commercial values of primary plant nutrients. The current values have been reviewed and no change in the values is proposed at this time. However, the effective dates are being changed to reflect the annual update. The assessed penalties for deficient fertilizers will be based on the values and charged to the manufacturer. The State Treasury will receive all unclaimed penalty fees.

**Social Impact**

All consumers of fertilizers will have more monetary protection when deficient fertilizers are detected. Manufacturers will exhibit more care in controlling their formulating processes to avoid a penalty.

**Economic Impact**

All consumers of fertilizer will be equitably compensated for their losses because these proposed values are accurately adjusted to current market prices.

**Regulatory Flexibility Analysis**

Both large and small businesses, as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., are affected by the proposed changes in the values of the fertilizers. However, differing standards are not deemed necessary because the changes are not burdensome and they reflect the current market value of the nutrients. Furthermore, the nutrient values are used in setting the penalties of manufacturers for compensation to farmers, all of whom are considered small businesses under the Act, when they purchase products that do not meet the analysis as advertised. The amendment in that way provides some measure of protection to small businesses.

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

2:69-1.11 Commercial values

(a) (No change.)

(b) These values shall be effective from [September 8, 1992] **September 24, 1993** through June 30, [1993] **1994**.

## BANKING

### (b)

### DIVISION OF REGULATORY AFFAIRS

### Fire Insurance

### Proposed New Rule: N.J.A.C. 3:1-13.2

Authorized By: Jeff Connor, Commissioner, Department of Banking.

Authority: N.J.S.A. 17:1-8.1; 17:11A-54; 17:11B-13; and 17:13-125.

Proposal Number: PRN 1993-434.

Submit comments by September 15, 1993 to:
Rule Comments
Attn: Stephen Szabatin
Deputy Commissioner
Department of Banking
CN 040
Trenton, NJ 08625

The agency proposal follows:

**Summary**

The Department of Banking proposes to adopt a new rule concerning the amount of fire insurance a lender is permitted to require incident to a mortgage loan. Current law does not restrict the amount of insurance a lender may require. However, insurance law provides that insurance companies may issue fire insurance policies to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss. N.J.S.A. 17:36-5.19.

A lender requiring a borrower to obtain fire insurance in the amount of the loan, even though the amount of the loan exceeds the replacement cost, is requiring a borrower to obtain a policy of insurance not permitted under N.J.S.A. 17:36-5.19. Further, since borrowers are unable to recover for more than the replacement value of improvements, any premiums paid for this excess coverage would provide them with no benefits.

To remedy this situation, the Department proposes a rule which provides that a lender may not require a borrower to obtain fire insurance in excess of the replacement value of the covered property. A mortgage lender is defined to mean a bank, savings bank, savings and loan association, credit union mortgage banker or broker, secondary mortgage loan licensee, or any other person who makes a loan secured by a first, second or subsequent mortgage on real property located in New Jersey.

**Social Impact**

The proposed rule may reduce the amount of fire insurance specified borrowers are required by lenders to obtain. This insurance in excess of the replacement cost provides no benefit to the lender, since borrowers are unable to recover for more than the replacement value of improvements. Accordingly, the rule would have a positive social benefit of eliminating this unnecessary insurance coverage.

**Economic Impact**

The proposed rule would have a positive economic impact on borrowers, as described above. There would be no corresponding negative economic impact on lenders, since insurance in excess of the replacement value provides the lender with no additional protection.

**Regulatory Flexibility Analysis**

Most lenders are small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed rule limits the ability of a lender to require insurance in excess of the replacement value. To ensure that borrowers are not required to obtain this unnecessary insurance, no differentiation based on business size is made.

**Full text** of the proposed new rule follows:

3:1-13.2 Amount of fire insurance required

(a) No mortgage lender shall, in connection with any application for a loan secured by a mortgage on real property located in New

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Jersey, require any mortgagor to obtain by purchase or otherwise a fire insurance policy in excess of the replacement value of the covered premises as permitted under N.J.S.A. 17:36-5.19 as a condition for granting such mortgage loan.

(b) For purposes of this section, the term mortgage lender means any bank, savings bank, savings and loan association, credit union, mortgage banker or broker, secondary mortgage loan licenses, or any other person who makes a loan secured by a first, second or subsequent mortgage on real property located in New Jersey.

## (a)

## DIVISION OF REGULATORY AFFAIRS

### Depository Institutions
### Compensation
### Proposed New Rules: N.J.A.C. 3:4-2

Authorized By: Jeff Connor, Commissioner, Department of Banking.

Authority: N.J.S.A. 17:1-8.1; 17:9A-8.10, 27.50 and 106; and 17:12B-72.

Proposal Number: PRN 1993-432.

Submit comments by September 15, 1993 to:
Rule Comments
Attn: Stephen Szabatin
Deputy Commissioner
Department of Banking
CN 040
Trenton, NJ 08625

The agency proposal follows:

**Summary**

The Department of Banking proposes to adopt new rules concerning the payment of stock options to directors, officers and employees of banks, savings banks and savings and loan associations.

The proposed rules first clarify that stock savings and loan associations are entitled to offer stock option plans as banks and savings banks are entitled to do. This is consistent with the Department's position of treating all chartered depositories in a similar manner, whenever possible.

The Department also proposes to permit banks, capital stock savings banks and capital stock savings and loan associations to allow directors to participate in stock option plans. To attract the most qualified persons for director positions, depositories need the flexibility to offer a wide range of compensation. It is anticipated that these rules will provide this flexibility.

A depository may not grant stock options to a director for less than the higher of the par value or 100 percent of the fair market value of the shares at the time the options are granted. Grants to officers and employees may not be for less than the higher of the par value or 85 percent of the fair market value of the shares at the time the options are granted. Stock option plans may not provide for the payment of cash to directors by the depository upon cancellation of the options.

**Social Impact**

The proposed rules will allow State depositories greater flexibility in compensating their directors, officers and employees. In this way, depositories will be able to attract the most qualified persons. To the extent that depositories are therefore able to operate more efficiently and profitably through this employment, the proposed rules will have a beneficial social impact.

**Economic Impact**

As indicated in the Social Impact statement, it is anticipated that these rules will assist depositories transact business more efficiently, and will therefore have a positive economic impact on the industry. Since no depository will be required to make stock options available, it is not anticipated that a negative economic impact will result from these proposed rules.

**Regulatory Flexibility Analysis**

The proposed rules permit depositories to offer stock options to directors. Many of these institutions are small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These proposed rules provide that a depository may not grant stock options to a director for less than the higher of the par value or 100 percent of the fair market value of the shares at the time the options are granted, and prohibit options from providing for the payment of cash to directors by the depository upon cancellation of the options. These compliance requirements minimize any negative impact which may accrue to a depository from issuing stock options. For this reason, no differentiation based on business size is made.

**Full text** of the proposed new rules follows:

SUBCHAPTER 2. COMPENSATION

3:4-2.1 Definitions

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

"Bank" shall have the same definition as provided in section 1 of P.L. 1948, c.67 (N.J.S.A. 17:9A-1).

"Depository" shall mean a bank, savings bank or savings and loan association, and includes a limited purpose trust company.

"Savings and loan association" shall mean a capital stock association established pursuant to L.1974, c.137 (17:12B-244 et seq.).

"Savings bank" shall mean a capital stock savings bank established pursuant to L.1982, c.9 (N.J.S.A. 17:9A-8.1 et seq.).

3:4-2.2 Stock option plans

(a) A bank may permit its directors, officers and employees to participate in a stock option plan established pursuant to N.J.S.A. 17:9A-27.50 et seq., and a savings bank may permit its directors, officers and employees to participate in a stock option plan established pursuant to N.J.S.A. 17:9A-8.10.

(b) A savings and loan association may permit its directors, officers and employees to participate in a stock option plan to the same extent as permitted for banks and savings banks so long as the association complies with N.J.S.A. 17:9A-27.50 et seq.

(c) A depository may not grant stock options to a director for less than the higher of the par value or 100 percent of the fair market value of the shares at the time the options are granted. A depository may not grant stock options to an officer or employee for less than the higher of the par value or 85 percent of the fair market value of the shares at the time the options are granted. Stock option plans may not provide for the payment of cash to directors by the depository upon cancellation of the options.

(d) A stock option plan must be adopted by the depository's board of directors and approved by the holders of two-thirds of the capital stock of the depository entitled to vote.

## (b)

## DIVISION OF REGULATORY AFFAIRS

### Disqualification of Directors
### Proposed Amendment: N.J.A.C. 3:6-15.2
### Proposed New Rule: N.J.A.C. 3:11-7.11

Authorized By: Jeff Connor, Commissioner, New Jersey Department of Banking.

Authority: N.J.S.A. 17:1-8.1 and 17:9A-104.

Proposal Number: PRN 1993-433.

Submit comments by September 15, 1993 to:
Rule Comments
Attn: Stephen Szabatin
Deputy Commissioner
Department of Banking
CN 040
Trenton, NJ 08625

The agency proposal follows:

**Summary**

This proposal amends the rules governing savings banks to provide that a director who defaults for 30 days in payment of an undisputed obligation to the savings bank ceases to be a director. This provision brings the savings bank rules into accord with the laws concerning bank

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directors. (See N.J.S.A. 17:9A-104.) In addition, the proposed new rule provides that a person who is disqualified for this reason is not eligible for reappointment to the board until the next annual meeting.

In addition, the proposed new rule clarifies that a director is disqualified when a corporation or partnership controlled by the director defaults for 30 days or more in payment of an undisputed obligation to the director's bank or savings bank. A director controls a corporation when the director has the power to directly or indirectly vote 25 percent or more of the voting stock, has the ability to control in any manner the election of a majority of the directors, or has the ability to exercise a controlling influence over the management and policies of the corporation. A director who is a general partner of a partnership controls that partnership.

**Social Impact**

Permitting a director to remain on the board after having defaulted on an undisputed obligation to the bank or savings bank would tend to reduce confidence in that institution, and depositories in general. To the extent that this rule clarifies that a director is removed upon such a default, it will advance confidence in the industry to the social benefit.

**Economic Impact**

This rule may encourage a director, and a corporation or partnership controlled by a director, to maintain a current position on all obligations to the director's bank or savings bank. To this extent, it will have a positive economic impact on the depository.

**Regulatory Flexibility Analysis**

Banks and savings banks are predominantly small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment and new rule require that the bank or savings bank remove a director when the director, or a corporation or partnership controlled by the director, defaults for 30 days on an undisputed obligation to the depository. To maintain confidence in the industry, it is necessary that all directors are disqualified upon such a default. Accordingly, no differentiation in business size is made.

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

(a) A savings bank may permit its officers and managers and their families and affiliates to become liable to the savings bank only under the same terms and conditions and to the same degree of liability as a bank permits its directors, officers or the corporations or partnerships of the officers or directors of a bank to become liable to a bank under the provision of Article 15 of The Banking Act of 1948 (N.J.S.A. 17:9A-71 et seq.) **and under N.J.S.A. 17:9A-104,** and the regulations issued pursuant [thereto] **to both.**

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

**3:11-7.11 Disqualification of directors**

**(a) A director of a bank who defaults for 30 days in payment of an undisputed obligation to the bank shall cease to be a director, and shall not be eligible for reappointment to the board until the next annual meeting.**

**(b) For purposes of (a) above, the following obligations shall constitute obligations of the director:**

**1. Obligations of the director; and**

**2. Obligations of a corporation or partnership which is controlled by the director.**

**(c) A director controls a corporation when the director has the power to directly or indirectly vote 25 percent or more of the voting stock, has the ability to control in any manner the election of a majority of the directors, or has the ability to exercise a controlling influence over the management and policies of the corporation. A director who is a general partner of a partnership controls that partnership for purposes of this section.**

---

# (a)

## DIVISION OF REGULATORY AFFAIRS

## Repair and Improvement Loans; Maximum Interest Rates

## Proposed Repeal: N.J.A.C. 3:31
## Proposed Amendment: N.J.A.C. 3:28-4.7
## Proposed New Rule: N.J.A.C. 3:28-4.12

Authorized By: Jeff Connor, Commissioner, Department of Banking.

Authority: N.J.S.A. 17:12B-197.

Proposal Number: PRN 1993-442.

Submit comments by September 15, 1993 to:
Stephen Szabatin, Deputy Commissioner
Department of Banking
CN 040
Trenton, NJ 08625

The agency proposal follows:

**Summary**

N.J.A.C. 3:31 was promulgated as emergency rules pursuant to N.J.S.A. 52:14B-4(c), on January 14, 1980. Its purpose at that time was to provide for home repair and improvement loans at a rate of interest which would encourage lending institutions to make funds available to the general public for this purpose. This rate was established at a maximum of 15 percent per year.

Subsequently, effective March 31, 1981, the Legislature amended N.J.S.A. 17:12B-160 to provide that interest charged on loans defined in N.J.S.A. 17:12B-158, "shall not exceed an amount calculated according to the actuarial method at a rate or rates agreed to by the association and the borrower." Thus, interest may be set at any rate which does not violate usury restrictions under N.J.S.A. 2C:21-19. The criminal usury rate under this section is 30 percent on loans to individuals and 50 percent on loans to corporations. The Department therefore proposes to repeal N.J.A.C. 3:31-2.2, as it conflicts with statutory law and no longer serves the purpose for which it was promulgated. N.J.A.C. 3:31-1.1 and 2.1, although indicated as part of the chapter repeal, are essentially being recodified and incorporated into N.J.A.C. 3:28 at N.J.A.C. 3:28-4.7 and 4.12.

**Social Impact**

The proposed repeal, new rule and amendment will have no significant social impact; rather, they will remove the confusion caused by N.J.A.C. 3:31-2.2, when reading this section together with N.J.S.A. 17:12B-160, because N.J.A.C. 3:31-2.2 imposed a 15 percent maximum interest rate to be charged on repair and improvement loans, whereas N.J.S.A. 17:12B-160 imposes no limit other than criminal usury restrictions.

The reorganizing of the sections regarding minimum requirements will place this information in the correct place for access and understanding.

**Economic Impact**

The proposed repeal, new rule and amendment will have no significant economic impact because the controlling laws on interest rates are found in State statutes, which allow for higher rates than are permitted by N.J.A.C. 3:31, and have in fact been in effect since 1981.

**Regulatory Flexibility Statement**

A regulatory flexibility analysis is not required because the proposed repeal, new rule and amendment do not impose reporting, recordkeeping or other compliance requirements on small businesses, as that term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-1 et seq. Although N.J.A.C. 3:28-4.7 and 4.12 have recordkeeping requirements, these are not newly imposed because in this rulemaking existing rules have been recodified. Further, the existing rules impose only the minimal reporting and recordkeeping requirements necessary to protect consumers involved in such loan activities. Therefore, no differing standards based on business size are offered.

**Full text** of the rules proposed for repeal and recodification can be found in the New Jersey Administrative Code at N.J.A.C. 3:31.

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

3:28-4.7 Account loans; **minimum requirements**

A subsidiary record shall be maintained for each account loan which shall be balanced and proved at least monthly. **In addition to the evidence of debt, the files for each loan shall contain the passbook and/or certificate or other evidence of membership pledged as collateral security for the loan. The files shall also contain any other documentation required by law or regulation.**

**3:28-4.12 Repair and improvement loans**

**In addition to the evidence of debt, the files for each property improvement loan made pursuant to N.J.S.A. 17:12B-157 shall contain an application, financial statement and/or credit report, a certified statement by the borrower or lender that repairs and/or improvements have been completed and other documentation required by law or regulation. The required documentation shall be the same as set forth in N.J.A.C. 3:27-1.4.**

# EDUCATION

## (a)

## STATE BOARD OF EDUCATION

## School Facility Lease Purchase Agreements

## Proposed Readoption with Amendments: N.J.A.C. 6:22A

Authorized By: State Board of Education, Mary Lee Fitzgerald, Secretary, State Board of Education and Commissioner, Department of Education.

Authority: N.J.S.A. 18A:4-15 and 18A:20-4.2(f).

Proposal Number: PRN 1993-428.

Submit written comments by September 15, 1993 to:
Elease E. Greene-Smith, Rules Analyst
New Jersey Department of Education
225 East State Street, CN 500
Trenton, New Jersey 08625-0500

The agency proposal follows:

**Summary**

Under the provisions of Executive Order No. 66(1978), the rules at N.J.A.C. 6:22A, School Facility Lease Purchase Agreements, will expire on December 19, 1993. As required by the Executive Order, the Department of Education has reviewed these rules and determined them to be necessary, reasonable and proper, as amended and supplemented, for the purpose for which they were originally promulgated. The proposed rules at N.J.A.C. 6:22A provide for the Department's approval process for original lease purchase applications and the refinancing and defeasance of existing lease purchase agreements.

A review of each section and the proposed amendments are as follows:

N.J.A.C. 6:22A-1.1 currently contains only a definition for the term school building. The section is being amended to include definitions of those terms commonly associated with lease purchase agreements, specifically, defeasance, effective interest cost, net issue proceeds, net present value cost savings, percentage of net present value cost savings, present value, and refinance.

The current N.J.A.C. 6:22A-1.2 has been amended to segregate the approval procedures for an original lease purchase agreement from the approval procedures for a refinance or defeasance of an existing lease purchase agreement.

N.J.A.C. 6:22A-1.2 sets forth the approval procedures for an original lease purchase agreement. A new paragraph 4 has been added to N.J.A.C. 6:22-1.2(a) to require district boards of education to adopt a resolution which projects the maximum level of funding for original lease purchase agreements. The proposed new subsection (c) at N.J.A.C. 6:22A-1.2 has been added to allow districts to include furniture and/or equipment in a lease purchase agreement when such items are used in conjunction with the completed project. Thus, under the proposed rules, districts would be permitted to include equipment (computers, copiers, etc.) and furniture (desks, chairs, etc.) in their financing when such items would be used for educational purposes in a new building, addition or renovated portion of the school. A new N.J.A.C. 6:22A-1.2(d) has been added which defines the public hearing process to be followed by districts prior to their adopting resolutions endorsing a lease purchase concept and approving the submission of a lease purchase application to the Commissioner of Education. The proposed new subsections (m) and (n) at N.J.A.C. 6:22A-1.2 have been added to identify the information to be filed with the Commissioner upon completion of the transaction.

Current N.J.A.C. 6:22A-1.2(c) and (d) have been recodified as subsections (e) and (f). N.J.A.C. 6:22A-1.2(e) has been amended to permit district boards of education to adopt resolutions to endorse and approve the advertisement of lease purchase agreements which are in excess of five years. This subsection, however, requires that such resolutions be made seven days after the second public hearing is held and with the affirmative vote of two-thirds of the full membership of the board. This section has also been amended to require a school district advertise and solicit proposals for the selection of an underwriter in addition to that of a lessor which is currently required. The recodified subsection (f) has been amended to require district boards of education to use a FORM 101A when requesting approval of a lease purchase agreement in excess of five years. Proposed N.J.A.C. 6:22A-1.2(g) identifies the documentation to be filed with the Commissioner when filing an Application to Lease Purchase Facilities. N.J.A.C. 6:22A-1.2(e) through (i) have been recodified as subsections (h) through (l). Recodified N.J.A.C. 6:22A-1.2(k) has also been amended to reflect a change in classification in the annual school budget statement. The implementation of Generally Accepted Accounting Principles (G.A.A.P.) separates lease purchase principal and interest payments between capital outlay and current expense, respectively.

N.J.A.C. 6:22A-1.3 sets forth the approval procedures to be followed when a district refinances a lease purchase agreement. N.J.A.C. 6:22A-1.3 is being proposed as a new rule to continue to provide administrative direction for local district boards of education in meeting the requirements of N.J.S.A. 18A:20-4.2. N.J.A.C. 6:22A-1.3(a) requires school districts proposing to refinance lease purchase agreements to adopt resolutions requesting the approval of the Commissioner of Education and the Local Finance Board in the Department of Community Affairs of the transaction. N.J.A.C. 6:22A-1.3(b) establishes the requirement that a FORM 201 be filed by district boards of education seeking approval to refinance a lease purchase agreement. N.J.A.C. 6:22A-1.3(c) identifies those documents which must be filed with a district's Application for Refinancing. N.J.A.C. 6:22A-1.3(d) and (e) establish the Commissioner's timelines for action on district Applications for Refinancing.

N.J.A.C. 6:22A-1.4 establishes the approval procedures to buy out a lease purchase agreement which is referred to as a defeasance. N.J.A.C. 6:22A-1.4 is being proposed as a new rule to continue to provide administrative direction for local district boards of education in meeting Department of Education requirements for the defeasance of lease purchase agreements.

N.J.A.C. 6:22A-1.4(a) requires school districts who defease lease purchase agreements through the issuance of general obligation bonds to adopt resolutions requesting the approval of the Commissioner of Education for the transaction. N.J.A.C. 6:22A-1.4(b) establishes the requirement that a FORM 201A be filed by district boards of education seeking approval for the defeasance of a lease purchase agreement and identifies those documents which must be filed with a district's Application for Defeasance. N.J.A.C. 6:22A-1.4(c) sets forth the requirement that the Application for Defeasance support a net present value cost savings and establishes that the application will be reviewed on the merits of the cost savings without consideration of any debt service aid. N.J.A.C. 6:22A-1.4(d) establishes the Commissioner's timelines for action on district Applications for Defeasance.

**Social Impact**

The proposed readoption and amendments to N.J.A.C. 6:22A in conjunction with requirements contained in the authorizing statute, N.J.S.A. 18A:20-4.2(f), will ensure that this method of financing is used only when the proposed project is in the best interest of the school district and its children and is consistent with the district's goals and objectives established pursuant to P.L. 1975, c.212, and when the cost and financial terms and conditions of the associated lease purchase agreement, or subsequent revision of the agreement, are reasonable and cost effective. The rules will also provide the public with two formal opportunities for comment and discussion.

Lease purchase agreements are essential to meet the State's mounting school facility needs, estimated at $6 billion. An increase in the birthrate and a movement of students from parochial to public schools because

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of current economic conditions has only increased the problem. Many of the State's children are suffering both physically and academically under existing facility conditions.

Despite overcrowding, deterioration, obsolescence and health and safety problems, voters in many districts continually defeat referendums for school construction debt. Without lease purchase agreements many school districts would face split sessions, excessive pupil to teacher ratios and fewer educational opportunities for their children. To date, 60 school districts have used this method of financing to provide approximately $700 million for projects which provided for safe and healthy classrooms, relieved overcrowding, established new educational programs and technological advancements and implemented other initiatives to achieve their constitutional mandate to provide a thorough and efficient system of free public schools.

The new rules on refinancing or buying out a lease purchase agreement will permit school districts to take advantage of the lowest interest rates in two decades. Districts buying out a lease purchase agreement may also qualify for State debt service aid. The savings generated may be used for additional educational programs and services and/or property tax relief.

**Economic Impact**

The proposed new rules in N.J.A.C. 6:22A have a positive economic impact for local boards of education and a negative economic impact for the State. The new rules for refinancing or defeasance of a lease purchase agreement permit local boards of education to take advantage of the lowest interest rates in two decades and to obtain significant reductions in or elimination of their lease purchase payments. The new rules for the defeasance of a lease purchase agreement permit local boards of education with voter or board of school estimate approval to buy out the lease purchase agreement before its term by issuing general obligation bonds. The conversion to bonds changes the annual payment from a general fund expenditure to a debt service expenditure. Local boards of education which are eligible for foundation aid would also be eligible for debt service aid which further decreases the local cost but increases the cost to the State.

The proposed readoption and amendments have no economic impact on the approval of new lease purchase agreements. The proposed rules for new lease purchase agreements merely readopt existing rules, make technical corrections for amendments to the authorizing statute and codify longstanding procedures necessary to fulfill the Department's statutory charge. Any economic impact is a result of the authorizing statute, not the proposed rules.

**Regulatory Flexibility Statement**

A regulatory flexibility analysis is not required because these rules do not impose reporting, recordkeeping, or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules impact solely upon New Jersey school districts and upon schools operated by the New Jersey Department of Education.

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

6:22A-1.1 [School building definition] **Definitions**

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

**"Defeasance" means the process by which a district board of education completes an early buy out of a lease purchase agreement by obtaining the approval of the voters or board of school estimate to issue general obligation bonds to acquire ownership of the property prior to the expiration of the agreement.**

**"Effective interest cost" means the semiannual discount rate which equates future payments relating to the bonds, including the principal, interest and associated expenses to the net issue proceeds.**

**"Net issue proceeds" means the par amount of the bonds plus accrued interest and original issue premium, less any original issue discount, underwriting spread, costs of issuance, insurance premium and letter of credit fees.**

**"Net present value cost savings" means the current value of a future payment or series of payments discounted at the effective interest cost.**

**"Percentage of net present value cost savings" means the total net present value cost savings divided by the principal amount of the prepaid certificates of participation.**

**"Present value" means the current value of a future payment, or series of payments discounted at an appropriate discount rate.**

**"Refinance" means the process by which a district board of education sells new certificates of participation at lower interest rates to refund all or a portion of the existing certificates of participation, thereby lowering the annual rental payments under the lease purchase agreement.**

[As used in this subchapter,] "[school] **School** building" means any educational facility or education support facilities necessary for a local district to achieve its goals and objectives pursuant to Chapter 212, Laws of 1975.

6:22A-1.2 Approval procedures **for an original lease purchase agreement**

(a) A district board of education planning to acquire a site and to construct a school building and/or to make additions, alterations, renovations and improvements to existing buildings or to acquire a site and building by lease purchase agreement shall comply with the following:

1. The district board of education shall have the site approved by the Bureau of Facility Planning Services in accordance with N.J.A.C. 6:22-1.2.

2. The district board of education shall have the educational specifications, schematic plans, preliminary plans, and final plans for a new building and/or for additions, alterations, renovations and improvements to existing buildings approved by the Bureau of Facility Planning Services in accordance with N.J.A.C. 6:22 and the State Uniform Construction Code prior to any party obtaining a construction permit.

3. The district board of education shall have the educational specifications[,] **and** schematic plans [and project cost estimate] approved by the Bureau of Facility Planning Services prior to obtaining the Commissioner's approval of a lease purchase agreement in excess of five years.

**4. The district board of education shall adopt a resolution on the projected maximum funding level.**

(b) A district board of education planning to transfer or lease land or rights or interests therein, including any building thereon to any party as a part of a lease purchase transaction involving a lease purchase agreement in excess of five years, shall have such transfer or lease to a third party documented by a ground lease agreement, which shall be submitted to the Commissioner for approval. [Such ground lease agreement shall follow a sample ground lease agreement prepared by the Commissioner.]

**(c) A district board of education may include the cost of related equipment and/or furniture in the overall project cost of a lease purchase agreement for a new school building, a renovated school building or additions made to an existing school building provided the cost of such equipment and/or furniture is amortized over the first five years of the lease purchase payment schedule in accordance with N.J.S.A. 18A:18A-42(f).**

**(d) A district board of education shall conduct two public hearings, prior to adoption of a resolution endorsing the lease purchase concept and approving the submission of an application to the Commissioner.**

**1. All provisions of the Open Public Meetings Act (N.J.S.A. 10:4-6 thru 21) shall be followed as well as:**

**i. The two public hearings shall be held at least 14 days apart;**

**ii. Notice of the public hearings shall be separately published at least once for each hearing in at least one newspaper published in the district and if no newspaper be published therein, then in at least one newspaper circulating in said district not less than seven days prior to the date fixed for each public hearing; and**

**iii. The notice shall fix a date, place and time for the holding of the public hearings and shall include a description of the proposed school building project, estimated cost and the proposed method of financing.**

**2. The public hearings shall provide the taxpayers and other interested persons an opportunity to present questions or other**

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**commentary to the district board of education with respect to the proposed school building project, estimated cost and the proposed method of financing.**

[(c)]**(e) Not soon than seven days after the second public hearing** [A] **a** district board of education [shall] **may, by an affirmative vote of at least two-thirds of the full membership of the board,** adopt a resolution endorsing approval of the lease purchase concept and authorizing the chief school administrator and/or board secretary to advertise and solicit proposals for the selection of a lessor **and underwriter** in connection with a lease purchase agreement and to request the approval of the Commissioner and the Local Finance Board in the Department of Community Affairs of a lease purchase agreement in excess of five years.

[(d)]**(f)** A district board of education requesting the Commissioner's approval of a lease purchase agreement in excess of five years shall submit to the Commissioner and the Local Finance Board in the Department of Community Affairs [an application on a form prepared] **an Application for Permission to Lease Purchase Facilities, Form 101A, prescribed** by the Commissioner **(this form is available at the Division of Financial Services, 225 East State Street, CN 500, Trenton, New Jersey)**, a copy of the ground lease agreement, if applicable, a lease with an option to purchase agreement or similar document, **and** an agent or trust agreement, if applicable[, and any other relevant information which the Commissioner may request to justify the need for the proposed lease purchase agreement].

**(g) A district board of education shall also file with the Commissioner the following documents:**

**1. A board resolution authorizing submission of Form 101A to the Commissioner;**

**2. A narrative which clearly establishes the relationship of the proposed project to the district's goals and objectives for a thorough and efficient education established pursuant to N.J.S.A. 18A:7A-1 et seq.;**

**3. Copies of board minutes for the two public hearings, resolution and vote on the projected maximum funding level, and the resolution endorsing approval of the lease purchase concept and authorizing the chief school administrator or board secretary to advertise for proposals for the selection of underwriter/lessor;**

**4. The lease purchase agreement which shall contain the following provisions:**

**i. Payments shall be subject to the annual appropriation of funds sufficient to meet the required payments or shall contain an annual cancellation clause pursuant to N.J.S.A. 18A:20-4.2(f);**

**ii. All construction contracts let by public school districts or let by developers or owners of property used for school purposes shall be competitively bid pursuant to N.J.S.A. 18A:20-4.2(f); and**

**iii. The district board of education at its sole discretion may refinance the lease purchase agreement or purchase the leased premises, by defeasance or otherwise, at any time during the lease period;**

**5. Evidence of clear title and appropriate title insurance to proposed building site(s) or any land stated in the ground lease;**

**6. A copy of the commitment or application for insurance or other credit enhancement for the proposed issuance of certificates of participation, if applicable;**

**7. Evidence the site can be serviced by all utilities necessary for the operation of the property;**

**8. Approval letters from the governmental agencies having jurisdiction over the development of the subject property, including, but not limited to the Department of Environmental Protection and Energy and the Pinelands Commission;**

**9. A copy of a letter from the Bureau of Facility Planning Services indicating:**

**i. Approval of the project's schematic plans, and educational specifications; or**

**ii. Conceptual approval of the proposed improvements, if approval of the schematic plans and educational specifications are not required;**

**10. Proposed credit ratings on the issue, and credit rating agencies;**

**11. A copy of a letter from the school district's county superintendent endorsing the lease purchase agreement and indicating the project's necessity for the school district to meet its goals and objectives for a thorough and efficient education;**

**12. A copy of the newspaper advertisement for the request for proposals;**

**13. The list of persons and/or firms to which the request for proposals was sent and the respondents to the request for proposals;**

**14. The comparative analysis of proposals showing the following:**

**i. The construction costs;**

**ii. The financing costs;**

**iii. The underwriting fees, legal fees and issuance expenses;**

**iv. If appropriate, the cost of insurance and/or a rating for the proposed issue;**

**v. The anticipated interest rate or methodology for calculating the interest rate at the time of issuance; and**

**vi. The proposal selected; and**

**15. If project is related to actual or anticipated overcrowding, documentation that the present educational facilities are or will be less than 80 percent adequate within five years and that the planned educational facilities will be fully utilized within 10 years.**

[(e)]**(h)** The Commissioner or a designee shall hold a conference prior to the Commissioner approving any request for approval of a lease purchase agreement in excess of five years. All documents required and the application must be submitted in duplicate and in final form and received at least 15 days prior to the scheduled conference. At the conference the district board of education shall be required to document and discuss at a minimum the following:

1. [A copy of the] **The** newspaper advertisement for the request for proposals;

2. The list of persons and/or firms to which the request for proposals was sent;

3. The responses to the request for proposals; **and**

4. The comparative analysis of proposals [showing the following:

i. The construction costs;

ii. The financing costs;

iii. The underwriting fees, legal fees and issuance expenses;

iv. If appropriate, the cost of financial insurance or a rating for the proposed issue;

v. The guaranteed interest rate or methodology for calculating the interest rate at the time of issuance;

vi. The proposal selected; and

vii. The proposed documents with any changes noted from the sample agreements].

[(f)]**(i)** Within 15 days after the conference for approval of a lease purchase agreement in excess of five years, the Commissioner shall endorse his or her consent upon the application, if **in accordance with N.J.S.A. 18A:20-4.2(f), as amended,** the Commissioner shall be satisfied that the lease purchase agreement is in the best interest of the school district, **and** that [the present educational facilities are less than 80 percent adequate, and that the planned educational facilities will be fully utilized within 10 years, or when] the relationship of the proposed lease purchase project to the district goals and objectives pursuant to Chapter 212, Laws of 1975 has clearly been established and the documents and information presented at the conference support the request of the district board of education for the proposed lease purchase agreement.

[(g)]**(j)** Lease purchase agreements in excess of five years shall be submitted to the Local Finance Board in the Department of Community Affairs for approval subsequent to approval by the Commissioner.

[(h)]**(k)** A district board of education having entered into a lease purchase agreement shall include in its annual [current expense] **general fund** budget the full rental payment attributable to a lease purchase agreement. **The principal portion of the payment shall be reflected in the capital outlay section and the interest portion of the payment shall be reflected in the general current expense section of the annual budget consistent with generally accepted accounting principles (GAAP).** The county superintendent of schools, **acting as proxy for the Commissioner,** shall not approve such budget in accordance with [N.J.A.C. 6:8-4.3(a)10iii(2)] **N.J.S.A. 18A:7D-27**

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when a district board of education does not include such rental payment in its [current expense] **annual general fund** budget unless the Commissioner or his or her designee has consented **in writing** to such approval.

[(i)]**(l)** A district board of education having entered into a lease purchase agreement in excess of five years shall not terminate, change or alter the approved lease purchase agreement and accompanying legal documents pertaining thereto, without first obtaining the written consent of the Commissioner.

**(m) Upon completion of the transaction, counsel shall file with the Commissioner an opinion stating the following:**

**1. The transaction is in conformance with local, state and Federal law; and**

**2. The parties hereto are properly organized; are in good standing; have the requisite power and have been properly authorized to enter into this transaction.**

**(n) Upon completion of a lease purchase agreement in excess of five years, a district board of education shall file the Official Statement of the transaction with the Commissioner.**

**1. The Official Statement (Prospectus) is a document published by the issuer which generally discloses material information on a new issue of municipal securities including the purposes of the issue, how the securities will be repaid, and the financial, economic and social characteristics of the issuing government.**

**6:22A-1.3 Approval procedures to refinance a lease purchase agreement**

**(a) A district board of education proposing to refinance a lease purchase agreement shall adopt a resolution requesting the approval of the Commissioner and the Local Finance Board in the Department of Community Affairs for said transaction.**

**(b) A district board of education requesting approval to refinance a lease purchase agreement shall submit to the Commissioner and the Local Finance Board in the Department of Community Affairs an Application for Refinancing, Form 201, prescribed by the Commissioner. This form is available at the Division of Financial Services, 225 East State Street, CN 500, Trenton, New Jersey.**

**(c) A district board of education shall also file with the Commissioner the following documents:**

**1. A copy of the board resolution requesting approval of the refinancing and the board's vote;**

**2. An opinion of counsel assuring the Commissioner that the refinancing is permitted under the original or modified lease purchase agreement and is in conformance with local, Federal and state statutes;**

**3. The list of persons and/or firms which the board of education contacted concerning the refinancing, the one selected and the specific reasons for the selection;**

**4. A copy of the amended rent payment schedule;**

**5. A schedule of sources and uses of the lease purchase agreement refinancing proceeds;**

**6. An analysis of the escrow account under the proposed refinancing;**

**7. A copy of the documents in final draft form with amendments and modifications, if necessary, to the lease purchase, ground lease, trustee or agent and assignment agreements, in order to effect the refinancing;**

**8. A copy of the updated insurance or other credit enhancement commitment, modified to cover refinancing, if applicable;**

**9. Proposed credit ratings on the issue, and credit rating agencies;**

**10. A detailed analysis of the percentage of net present value cost savings to the school district of at least three percent using the effective interest cost method as the discount rate based on an analysis of the total refunding issue to include the following for each payment:**

**i. Date;**

**ii. Prior debt service;**

**iii. New debt service;**

**iv. Savings (prior debt service minus new debt service);**

**v. Present value factor;**

**vi. Present value savings (savings times present value factor);**

**vii. Cumulative present value savings; and**

**viii. Totals of items (c)10ii through vii above.**

**(d) Within 15 days after the receipt of the Application for refinancing—Form 201 and related documents, the Commissioner shall endorse his or her consent upon the application, if the Commissioner shall be satisfied that the refinancing is in the best interest of the school district.**

**(e) An application to refinance a lease purchase agreement shall be submitted to the Local Finance Board in the Department of Community Affairs for approval subsequent to approval by the Commissioner.**

**6:22A-1.4 Approval procedures for a defeasance of a lease purchase agreement**

**(a) A district board of education proposing to seek voter or board of school estimate approval for the defeasance of a lease purchase agreement through the issuance of general obligation bonds shall adopt a resolution requesting the approval of the Commissioner for said transaction.**

**(b) A district board of education requesting approval for the defeasance of a lease purchase agreement shall submit to the Commissioner an Application for Defeasance, Form 201A, prescribed by the Commissioner (this form is available at the Division of Financial Services, 225 East State Street, CN 500, Trenton, New Jersey) and the following documents:**

**1. A copy of the board resolution requesting the Commissioner's approval of the defeasance of the lease purchase agreement through the issuance of general obligation bonds and the board's vote;**

**2. An opinion of counsel assuring the Commissioner that the prepayment of the lease purchase agreement is permitted under the original or modified lease purchase agreement and is in conformance with local, state and Federal statutes;**

**3. A copy of the documents in final draft form with amendments and modifications, if necessary, to the lease purchase, ground lease, trustee or agent and assignment agreements, in order to effect the defeasance;**

**4. A schedule of sources and uses of bond issue proceeds;**

**5. A detailed analysis of the percentage of net present value cost savings to the school district using the effective interest cost method as the discount rate based on an analysis of the total new bond issue to include the following for each payment:**

**i. Date;**

**ii. Prior debt service;**

**iii. New debt service;**

**iv. Savings (prior debt service minus new debt service);**

**v. Present value factor;**

**vi. Present value savings (savings times present value factor);**

**vii. Cumulative present value savings; and**

**viii. Totals of items (b)5ii through vii above.**

**(c) The application shall support a net present value cost savings and will be reviewed strictly on the merits of the cost savings without consideration of any debt service aid to which the district board of education may be entitled.**

**(d) Within 15 days after the receipt of the Application for Defeasance—Form 201A and related documents, the Commissioner shall endorse his or her consent upon the application, if the Commissioner shall be satisfied that the defeasance of the lease purchase agreement is in the best interest of the school district. Such approval is contingent upon board of school estimate approval or voter adoption of the specific ballot question as applicable.**

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# (a)

## STATE BOARD OF EDUCATION

## Marie H. Katzenbach School for the Deaf

## Proposed Readoption with Amendments: N.J.A.C. 6:78

Authorized By: State Board of Education, Mary Lee Fitzgerald, Secretary, State Board of Education and Commissioner, Department of Education.

Authority: N.J.S.A. 18A:1-1, 18A:4-15, 18A:6-10 et seq., 18A:39-1, 18A:46-1 et seq., 18A:60-2 to 18A:60-3, and 18A:61-1 et seq.

Proposal Number: PRN 1993-427.

Submit written comments by September 15, 1993 to:
Elease E. Greene-Smith, Rules Analyst
New Jersey Department of Education
225 East State Street, CN 500
Trenton, New Jersey 08625-0500

The agency proposal follows:

**Summary**

Under the provisions of Executive Order No. 66(1978), the rules at N.J.A.C. 6:78 will expire on November 7, 1993. As required by the Executive Order, the Department of Education has reviewed these rules and determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated. The State Board is proposing to readopt these rules with amendments.

The rules contained in this chapter were originally adopted prior to September 1, 1969, and set forth the purpose and general provisions for the administration of educational, residential and daily management of the Marie H. Katzenbach School for the Deaf.

The proposed amendments clarify the cost of attendance, the existence of a vocational component at the high school level and state more clearly that the primary handicap of the student applying to the Katzenbach school must be that of deafness. The admissions procedures are being amended to conform to the Chapter II recommendation #4 of the Federal Commission on the Education of the Deaf.

A review of each of the sections of N.J.A.C. 6:78 follows:

N.J.A.C. 6:78-1.1, Function of the Marie H. Katzenbach School, describes the purpose of the chapter. It is the intent of these rules to define the function of the Marie H. Katzenbach School for the Deaf, and set forth the high school graduation requirements for Katzenbach School students. The proposed amendments to this subchapter clarify the cost of attendance and the existence of a vocational component at the high school level.

N.J.A.C. 6:78-1.2, Admission requirements, outlines the admission process and criteria for pupils making application to the Katzenbach School. The proposed amendments to N.J.A.C. 6:78-1.2(e)1 state more clearly the special education classifications required for application to Katzenbach School. The admission procedures are further being amended to make them consistent with the Chapter II recommendation #4 of the Federal Commission on the Education of the Deaf.

N.J.A.C. 6:78-1.3, Transportation, sets forth the procedures for transporting residential pupils, and establishes the eligibility of out-of-State pupils. These rules require that residential placements not be restricted by the geographic location of pupil residence. No changes are being proposed to this section.

**Social Impact**

It is expected that the readoption of N.J.A.C. 6:78, with the proposed amendments, will have a positive social impact. Since their adoption these rules have provided general guidance for the supervision and coordination of educational, residential and daily management of the Marie H. Katzenbach School for the Deaf. These rules are being readopted, with amendments, to continue to provide administrative direction to the Marie H. Katzenbach School for the Deaf in meeting the statutory requirements set forth in N.J.S.A. 18A:61 for the training and educating of deaf children.

The proposed admission amendments will help bring clearer focus to the profile of the child making application to the Katzenbach school. It is anticipated that the proposed amendments will not have significant impact on student eligibility. All other amendments to N.J.A.C. 6:78 have been to clarify existing requirements.

**Economic Impact**

The readoption of these rules will cause no change from the status quo. There should be no economic impact upon the pupils admitted to the Marie H. Katzenbach School for the Deaf as N.J.S.A. 18A:61 requires that such training and education be tuition free. Marie H. Katzenbach School is supported by both State and local funding. The State bears 56 percent of the operating costs. Additionally the proposed amendments are not anticipated to have any economic impact in that they reflect only clarification of existing requirements.

**Regulatory Flexibility Analysis**

The proposed readoption with amendments impose no reporting, recordkeeping or other compliance requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules concern the function, admission requirements and transportation policies of the Marie H. Katzenbach School for the Deaf. A regulatory flexibility analysis is, therefore, not required.

**Full text** of the proposed readoption can be found in the New Jersey Administrative Code at N.J.A.C. 6:78.

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

6:78-1.1 Function of the Marie H. Katzenbach School

(a) The function of the Marie H. Katzenbach School for the Deaf is to provide [tuition-free] residential and day education facilities and instruction for auditorily handicapped children from birth through 21 years of age, **at no expense to parents or guardians residing in the State,** in the following areas:

1.-2. (No change.)

3. [Post-secondary] **Vocational** education.

(b) (No change.)

6:78-1.2 Admission requirements

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

(e) All applicants of suitable age and capacity for instruction and legal residents of the State shall be eligible for admission. The following criteria shall be utilized for admission:

1. (No change.)

2. Suitable capacity for instruction for each applicant shall be determined by the admissions committee assessing the applicant's [present levels of educational performance and adaptive behavior, including academic achievement, cognitive functioning, personal and social development, health status, language proficiency, communication style, physical education and recreation needs, and prevocational, vocational and self-help skills] **communicative needs and the preferred mode of communication; linguistic needs; severity of hearing loss and the potential for using residual hearing; academic level and style of learning; social needs; placement preference; emotional needs; individual motivation; and Deaf cultural needs. Further assessment shall also be made on health status; self-help skills; physical education and recreation needs; and prevocational and vocational skills.** This determination shall be made upon review of the completed application, the results of the on-site screening and the ability of the school program to fulfill the requirements of the applicant's individualized education program.

3. (No change.)

(f)-(i) (No change.)

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# HIGHER EDUCATION

## (a)

## BOARD OF HIGHER EDUCATION

### Tuition Policies for Public Institutions

### Proposed Amendments: N.J.A.C. 9:5-2.1, 2.2, 2.3 and 2.5

### Proposed New Rule: N.J.A.C. 9:5-2.7

Authorized By: Board of Higher Education, Edward D. Goldberg, Chancellor and Secretary.

Authority: N.J.S.A. 18A:62-3, 18A:62-4 and 18A:64-13.4.

Proposal Number: PRN 1993-452.

Submit comments by September 15, 1993 to:
Valerie Van Baaren, Esq.
Administrative Practice Officer
Department of Higher Education
20 West State Street
CN 542
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

On July 7, 1992, the New Jersey Legislature enacted P.L. 1992 c.45 ("Act") which became effective immediately. The Act extends the existing unemployment persons tuition waiver statute by including Rutgers, The State University and the University of Medicine and Dentistry of New Jersey. The statute previously applied only to the State colleges, county colleges and the New Jersey Institute of Technology. Specifically, the legislation permits persons who have been in the labor market for at least two years and are unemployed or have received lay-off notices as a result of factory or plant closings, to enroll in job-related courses at any public institution of higher education and to have their tuition waived. In addition, the legislation expands the definition of "job training course."

In order to conform regulations to the Act, the Department proposes to amend N.J.A.C. 9:5-2.1 regarding the necessary submissions from eligible individuals seeking to enroll with a tuition waiver and to clarify at which institutions individuals are eligible to enroll. The Department proposes to amend N.J.A.C. 9:5-2.2 to specify responsibility for filing financial aid applications and to conform rules to the current use of one form for both State and Federal financial aid. Further, amendments proposed to N.J.A.C. 9:5-2.3 require courses or programs for eligible individuals to focus on identifiable job skills or to be indicated in the individual's approved training plan. In addition, proposed amendments allow institutions to designate separate registration periods for individuals seeking to enroll in the program. Proposed amendments to N.J.A.C. 9:5-2.5 specify that rules regarding academic progress and standards for admission of students into specific degree programs would apply. Finally, the Department proposes a new rule, N.J.A.C. 9:5-2.7, to specify financial obligations of individuals enrolled in the program.

**Social Impact**

The proposed amendments and new rule extend the existing unemployed persons tuition waiver by including Rutgers, The State University and the University of Medicine and Dentistry of New Jersey. The program will continue to be available to individuals provided that they are not eligible for any available State or Federal student financial aid, available enrollment space permits, and tuition paying students constitute the minimum number required for the course. The proposed amendments and new rule will increase opportunities for unemployed persons to acquire training in areas which will assist them in gaining reemployment.

**Economic Impact**

The extension of tuition waivers to Rutgers, The State University and the University of Medicine and Dentistry of New Jersey will have a positive economic impact on the lives of unemployed residents who wish to attend these universities. In addition, the tuition waivers will assist in the development of a trained workforce to meet the needs of businesses, industry, and the public and private sectors.

**Regulatory Flexibility Statement**

A regulatory flexibility analysis is not required since the proposed amendments and new rule do not impose reporting, recordkeeping or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendments and new rule set forth the criteria for free tuition for unemployed persons attending the State's public colleges and universities. These entities do not constitute small businesses within the meaning of the statute.

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

9:5-2.1 Proof of eligibility

[(a) Eligible individuals seeking to enroll under the job training program shall sign a statement, as prepared by the institution, verifying their past presence in the labor market for at least two years, their unemployed status or receipt of a layoff notice as proof of eligibility to participate in the program.]

[(b)]**(a)** Eligible individuals [currently employed] **seeking to enroll under the job training program** must submit [proof of recognition of their unemployed status by the New Jersey Department of Labor, Division of Employment Services,] to the institution **of higher education documentation from the Department of Labor, Division of Employment Services verifying their past presence in the labor market for at least two years and their unemployed status or receipt of a layoff notice as proof of eligibility or an approved training plan from the Division of Employment Services.** Said proof of eligibility must be dated no earlier than 30 days prior to the college's course registration day for the semester in which the job training course is to be taken.

[(c) For the purpose of determining eligibility, presence in the labor market for at least two years shall be defined as either full-time employment or the active pursuit of full-time employment or a combination thereof extending over at least a two-year period.]

[(d)]**(b)** [Any institution may require further proof of eligibility if it is] **If** deemed necessary, **an institution may allow an individual to register for courses pending receipt of Department of Labor verification.**

**(c) Eligible individuals may seek to enroll in any New Jersey public institution of higher education regardless of their county of residence. However, charge-backs pursuant to N.J.A.C. 9:4-1.5 shall not apply for unemployed persons. Eligible individuals who wish to attend a county college must first apply to the college within their county of residence.**

9:5-2.2 Eligibility for financial aid

[(a) Eligible individuals seeking to enroll under this program must complete a New Jersey Financial Aid Form to determine possible eligibility for financial aid. Those seeking to attend on a part-time basis must only complete a Federal financial aid form.]

[(b)]**(a)** Each **eligible** individual **seeking to enroll in credit courses under this program** is responsible for [completing the form] **filing a financial aid application** and providing the institution with all information necessary to determine possible financial aid eligibility.

[(c)]**(b)** [Financial aid shall include] **In determining eligibility for financial aid, the institution shall consider** both State and Federal sources of aid including grants, scholarships and any other sources of financial aid available to the institution's general student population, but shall not include loans.

Recodify existing (d) and (c) as **(c) and (d)** (No change in text.)

9:5-2.3 Eligible coursework

(a) Each institution shall ordinarily [designate] **make** all of its course offerings [for eligibility] **eligible** under this program. [Customized courses that are underwritten by specific employers for the benefit of their respective employees may be exempted from eligibility under this program.] **However, a given course or program shall focus on an identifiable job skill or prerequisite skills for the specific job skill or shall be indicated in the individual's training plan approved by Division of Employment Services.**

**(b) An individual's eligibility for a given course or program shall be dependent on possession of appropriate prerequisite skills as**

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**determined by each institution. The institution may designate basic skills and other prerequisite courses as eligible course offerings under this program.**

**(c) Customized courses that are underwritten by specific employers for the benefit of their respective employees may be exempted from eligibility under this program.**

[(b)]**(d)** Only those courses in which [classroom] **enrollment** space is available and tuition paying students constitute the minimum number required for the course shall be open to eligible individuals under this program.

**(e) Institutions may designate separate registration periods for eligible individuals seeking to enroll in the program, ordinarily after the registration period for tuition paying students is completed.**

9:5-2.5 Application of general institutional rules

When not inconsistent with applicable statutes or these [regulations] **rules**, students participating under this program shall be governed by those procedures and rules applicable to each institution's regularly enrolled student population, **including rules regarding academic progress and standards for the admission of students into specific degree programs at the undergraduate or graduate level.**

**9:5-2.7 Financial obligation of eligible individual**

**(a) Institutions may charge individuals seeking to enroll in the program an application fee not to exceed $20.00 per academic term.**

**(b) Individuals seeking to enroll in the program will be responsible for the cost of equipment, materials, and text books.**

**(c) The institution shall apply training grant funds pursuant to P.L. 1992, c.43 or financial aid, other than loans, to the total tuition and fees for the applicable academic term. The institution shall waive any remaining balance, less the charges allowable under (a) and (b) above.**

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# (a)

## STUDENT ASSISTANCE BOARD

## Paul Douglas Teacher Scholarship Program

## Proposed Amendments: N.J.A.C. 9:7-9.1 and 9.3 through 9.15

## Proposed Repeal: N.J.A.C. 9:7-9.2

Authorized By: Student Assistance Board, M. Wilma Harris, Chairperson.

Authority: N.J.S.A. 18A:71-15.3, Title V, Part E of the Higher Education Act of 1965, as amended by the Human Services Reauthorization Act of 1984, 20 U.S.C. 1119d-8, the Higher Education Technical Amendments Act of 1987 and the Higher Education Amendments of 1992.

Proposal Number: PRN 1993-453.

Submit written comments by September 15, 1993 to:

Valerie Van Baaren, Esq.
Administrative Practice Officer
Department of Higher Education
20 West State Street
CN 542
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

The Paul Douglas Teacher Scholarship Program is a Federal initiative designed to encourage and enable outstanding high school graduates to pursue teaching careers at the preschool, elementary or secondary school level by providing competitive scholarships for postsecondary education leading to teacher certification. Federal requirements for administering the program were recently revised under the Higher Education Amendments of 1992. In light of the legislation and proposed new Federal regulations, as well as the recent approval by the U.S. Department of Education of New Jersey's amended "Application to Participate" in the program, the Department of Higher Education must realign the corresponding State rules. As a result, the individual rules incorporated within N.J.A.C. 9:7-9 have been cited below with a brief explanation for the proposed amendments and proposed repeal.

N.J.A.C. 9:7-9.1 has been amended to incorporate all provisions in the new Federal code and to obviate the necessity to amend these references in the future.

N.J.A.C. 9:7-9.2 has been repealed since the existing definitions no longer apply and should be deleted. Former eligibility language in statute that had specified "degree program leading to teacher certification" is superseded by "course of study leading to teacher certification." The Department of Higher Education is awaiting interpretation of the new language from the U.S. Department of Education and such interpretation would be incorporated by reference in N.J.A.C. 9:7-9.1. Since the adoption of Federal regulations has not yet been completed, the Department of Higher Education would provide further clarification in the form of "definitions" only if final Federal regulations require additional explanation.

N.J.A.C. 9:7-9.3 has been revised to include General Education Development (GED) certificate recipients in keeping with Federal requirements. In addition, states cannot preserve their former minimum grade point average (GPA) requirements for collegiate applicants.

N.J.A.C. 9:7-9.4 has been amended to provide further clarification as to the accreditation of an eligible institution of attendance and also reflects the new Federal language concerning an applicant pursuing a "course of study leading to teacher certification" as cited above in N.J.A.C. 9:7-9.2. The Department of Higher Education is awaiting interpretation of whether the revised Federal requirements may preclude students who seek employment in the teaching field through non-traditional routes to teacher certification such as, New Jersey's "Alternate Route" method. Therefore, the reference to "Alternate Route" is being deleted until such time as Federal requirements are defined.

N.J.A.C. 9:7-9.5 incorporates a change in the Federal statute which provides that a Paul Douglas Teacher Scholarship shall not be reduced on the basis of a scholar's receipt of other forms of Federal student assistance, but must be taken into account in determining eligibility for other forms of student assistance.

N.J.A.C. 9:7-9.6 has been revised to include submission of GED test results for eligiblility in lieu of an official secondary school transcript including class rank and incorporates any other documentation which may be mandated by Federal code.

N.J.A.C. 9:7-9.7 has been amended to accommodate the mandated recruitment and special consideration of eligible candidates who are from economically and geographically disadvantaged backgrounds and certain others as specified in the Federal code.

N.J.A.C. 9:7-9.8 provides consistency with new Federal language and further clarification in the existing State rule.

N.J.A.C. 9:7-9.9 broadens the allowable service component, as authorized in statute, to include teaching in a nonprofit school that serves students with disabilities or limited English proficient students.

N.J.A.C. 9:7-9.10 through 9.15 have been updated to reflect the new Federal language and requirements and/or to reinforce existing administrative practice. In order to provide additional clarification of certain other specific changes within these sections, the following relative subsections are summarized:

N.J.A.C. 9:7-9.10(c)1: The proposed Federal regulations amend provisions regarding the scholarship agreement and teaching obligation to allow for candidates who are teaching the "equivalent" of full-time but may only possess a signed contract that indicates part-time. Therefore, the requirement for submission of a bona fide "full-time" teaching agreement is no longer applicable.

N.J.A.C. 9:7-9.11(a)1: Since preliminary interpretation of revised Federal regulations indicates a shift to broaden a scholar's ability to satisfy his or her teaching obligation, the restriction that limits authorized teaching service for reduction of scholarship balances to beyond one-quarter of a school year is being deleted.

N.J.A.C. 9:7-9.11(b): Pursuant to the new Federal language in statute that supersedes "degree program leading to teacher certification" with "course of study leading to teacher certification," all references to "degree" program have been deleted.

N.J.A.C. 9:7-9.11(c): The U.S. Secretary of Education prescribes the interest rate that state agencies must use. As yet, the Department of Higher Education has received no information on how this new interest rate will be established. Therefore, the reference to the former interest rate index has been deleted.

N.J.A.C. 9:7-9.13(a)1: Incorporates the change in impairment criteria made by Federal statute.

N.J.A.C. 9:7-9.14: The Student Assistance Board has deleted direct responsibility for individual case determinations and appeals to the

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applicable program director within the Department of Higher Education. This change updates the regulations in accordance with the process approved by the Student Assistance Board.

**Social Impact**

The Paul Douglas Teacher Scholarship Program provides scholarship assistance for postsecondary education of $5,000 per year to qualified applicants wishing to pursue teaching careers at the preschool, elementary or secondary school level. Qualified candidates need not repay the scholarship as long as they meet the teaching obligations as specified in Federal and State regulations. The proposed amendments and repeal continue to establish consistency in State rules with revised Federal regulations so that New Jersey can meet all Federal requirements for continued funding of the program, and thereby provide this much needed assistance to its students wishing to pursue teaching careers.

**Economic Impact**

The proposed amendments and repeal will not affect the current annual award amount of $5,000 for which students may qualify under the Paul Douglas Teacher Scholarship Program. The number of awards granted to qualified students within an academic year will continue to remain within the limits of Federal funding for the program.

**Regulatory Flexibility Statement**

A regulatory flexibility analysis is not required because the proposed amendments and repeal do not impose reporting, recordkeeping or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments and repeal incorporate recent changes in Federal legislation and regulations for the Paul Douglas Teacher Scholarship Program for students wishing to pursue teaching careers.

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

9:7-9.1 Rules and statutes incorporated by reference

(a) The part of the Code of Federal Regulations known as 34 C.F.R. 653 [through and including 34 C.F.R. 653.42] (as of November 25, 1987) including all subsequent amendments and supplements is hereby adopted as rules and incorporated within this subchapter.

(b) The part of the United States Code known as Title 20, Chapter 28, Subchapter [IV] **V**, Part D, 20 U.S.C. 1111 (as of October 17, 1986) including all subsequent amendments and supplements is hereby adopted as rules and incorporated within this subchapter.

(c) (No change.)

9:7-9.2 [Definitions] **(Reserved)**

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

"Alternate route" means the method of receiving approval from the New Jersey Department of Education to teach at the elementary or secondary school level pursuant to the provisions of N.J.A.C. 6:11-5.1, 5.2, 5.3 and 5.4.

"Degree program leading to teacher certification" means an undergraduate teacher preparation degree program which curriculum leads to a recommendation for a state instructional certificate awarded by a department of education of any state or any other undergraduate degree program in which the student enrolled has expressed the intention to utilize such degree for the purpose of securing an instructional certificate awarded by a department of education of any state, including any graduate study required to obtain an initial instructional certificate.

"Installment promissory note" means the promissory note signed by the scholar which sets forth the specific terms of repayment of previously received scholarship monies and interest in lieu of reduction of scholarship balances through teaching service pursuant to N.J.A.C. 9:7-9.9.

"Interim promissory note" means the promissory note signed by the scholar upon receipt of each disbursement of scholarship funds whereby the scholar promises to repay such funds plus interest unless teaching service is performed pursuant to N.J.A.C. 9:7-9.9.]

9:7-9.3 Academic requirements for application

[(a)] An applicant for the program must[:

1. Rank] **rank** in the top 10 percent of his or her secondary school graduating class[; and] **or have General Education Development (GED) test scores equivalent to ranking in the top 10 percent of the high school graduates in the state, or nationally, in the academic year for which the eligibility determination is being made.**

[2. If a collegiate student at the sophomore level or above, have a cumulative grade point average (GPA) of at least 2.5.]

9:7-9.4 Attendance in an eligible institution

An applicant must be enrolled or plan to enroll [in an accredited college or university] on a full-time basis [in a degree program] **at an institution of higher education that is currently accredited by a nationally recognized accrediting agency or association, in accordance with the Federal codes referenced in N.J.A.C. 9:7-9.1(a) and (b). In addition, the applicant must be pursuing a course of study** leading to a teaching certificate [or has indicated an intent to seek employment in the teaching field through the "Alternate Route" method (or any such program approved for use in other states)] but not including graduate study that is not required for initial teacher certification.

9:7-9.5 Amount of scholarship

(a) The Student Assistance Board [may award scholarships without regard to the need of the recipient] **shall award scholarships in accordance with the Code of Federal Regulations and United States Code referenced in N.J.A.C. 9:7-9.1(a) and (b)**.

(b) The amount of each scholarship shall be $5,000 per year; provided, however, a recipient shall not receive an amount which, when combined with other financial aid, would exceed the cost of college attendance as defined by the institution. **A scholarship shall not be reduced on the basis of the student's receipt of other forms of Federal student assistance, but shall be taken into account in determining the eligibility of the student for those other forms of Federal financial assistance.**

[(c) A scholarship shall not be awarded if the application of the provisions of (b) above would result in an award of less than $2,000 for the academic year.]

[(d)](c) Awards may be made on a semester, term, or half-year basis.

9:7-9.6 Application procedures

(a) An applicant must submit the following information:

1. (No change.)

2. Two written recommendations from college or secondary school administrators, guidance counselors, **community leaders** or teachers attesting to the applicant's interest in and aptitude for teaching; and

3. An official secondary school transcript including class rank[;] **or an official General Education Development (GED) test result notification; and**

4. (No change.)

5. Scholastic Aptitude Test (SAT) scores or the equivalent of the American College Test (ACT) for those applicants who have not yet attended college[.]; **and**

**6. Any certifications required in accordance with the Code of Federal Regulations and United States Code referenced in N.J.A.C. 9:7-9.1(a) and (b).**

(b) (No change.)

9:7-9.7 Criteria for scholarships

(a) The Student Assistance Board will consider the following criteria in determining scholarship recipients:

1. Class rank **or General Education Development (GED) test scores**; and

2.-3. (No change.)

4. Other [documents] **information** provided by **or on behalf of** the applicant.

(b) Scholarships will be awarded [without regard to sex, race, handicapping condition, creed, or economic background] **in accordance with all applicable requirements for special consideration as provided in the Federal codes referenced in N.J.A.C. 9:7-9.1(a) and (b)**.

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9:7-9.8 Renewal of scholarship eligibility

(a) In order to maintain eligibility for a scholarship a scholar must be:

1.-2. (No change.)

3. Maintaining satisfactory progress **toward a degree, or if the student already has a degree, toward teacher certification,** as determined by the [attending] institution **the student is attending** [and in accordance with Federal regulations as established in 34 C.F.R. 668.16(e)].

(b) (No change.)

9:7-9.9 Teaching obligations of the scholarship recipient

(a) The scholar shall teach on a full-time basis in any state for a period of not less than two years for each year for which he or she received a Paul Douglas Teacher Scholarship, in a public or private nonprofit preschool, elementary, or secondary school, [or in a public or private nonprofit preschool, elementary, or secondary education program] **including a private nonprofit school that serves students with disabilities or limited English proficient students.**

(b) The requirement set forth in (a) above to teach two years for each year of scholarship assistance is reduced by one-half if the scholar teaches on a full-time basis in a teacher shortage area designated by the U.S. Secretary of Education as provided by [section 428(b)(4) of the Higher Education Act of 1965, as amended] **the Code of Federal Regulations and United States Code referenced in N.J.A.C. 9:7-9.1(a) and (b).**

(c) (No change.)

9:7-9.10 Reduction of scholarship balance

(a) Reduction of the scholarship balance is predicated upon [obtaining a baccalaureate degree] **completion of the postsecondary education for which the Paul Douglas Teacher Scholarship was awarded** and providing teacher service as specified in N.J.A.C. 9:7-9.9. Depending upon the location, **nature** and duration of the teaching assignment, the total principal sum of the Interim Promissory Note including any accrued, capitalized interest will be reduced for service rendered within 10 years after completing the postsecondary education [degree program] for which the scholarship was awarded.

(b) (No change.)

(c) The scholar's total scholarship balance shall be reduced each year based on the submission on an annual basis of a notarized copy of:

1. The signed contract between the district board of education or its equivalent and the borrower indicating a [full-time] teaching agreement is in force, submitted by a date specified by the Department of Higher Education, Office of Student Assistance; and

2. A letter **or other appropriate certification** from the chief school administrator submitted by a date specified by the Department of Higher Education, **Office of Student Assistance** indicating a year of service has been completed.

**(d) Exceptions to (c)1 and 2 above will be considered only if permitted under the provisions of the Code of Federal Regulations and United States Code referenced in N.J.A.C. 9:7-9.1(a) and (b).**

9:7-9.11 Repayment schedule for failure to meet teaching obligations or withdrawal from [undergraduate degree] **postsecondary** program leading to teacher certification

(a) If the scholar fails to meet the teaching obligations described in N.J.A.C. 9:7-9.9, or if the scholar ceases to pursue a [postsecondary degree program] **course of study** leading to certification as a teacher at the preschool, elementary or secondary level, the scholar shall:

1. Repay the amount of the scholarships received, prorated according to the fraction of the teaching obligation not completed, as determined by the Department of Higher Education, Office of Student Assistance[, provided, however, that teaching service of less than one-quarter of a school year shall not be eligible for reduction of scholarship balances]; and

2. Pay a simple per annum interest charge on the outstanding principal as set forth in (c) below; and

3. (No change.)

(b) The interest charge accrues from the date of the initial scholarship payment if the scholar has ceased to pursue the postsecondary education [degree] program for which the scholarship was awarded, or the day after that portion of the scholarship period for which the teaching obligation has been fulfilled.

(c) The interest charge shall be adjusted annually, from the time interest begins to accrue to the time the repayment period begins as described in (d) below, and shall be set by the U.S. Secretary of Education [at a rate which in no event is higher than the rate applicable to loans under Part B of Title IV, HEA, during the same 12-month period]. The interest rate applicable during the repayment period is the interest rate prescribed by the Secretary which is in effect as of the beginning date of the repayment period.

(d) The scholar shall enter repayment status on the first day of the first calendar month after:

1. The scholar has ceased to pursue the postsecondary education [degree] program leading to teacher certification, but not before six months has elapsed after the cessation of the scholar's full-time enrollment in such a program; or

2.-3. (No change.)

(e)-(j) (No change.)

9:7-9.12 Postponement of repayment schedule

(a) A scholar is not considered in violation of the repayment schedule and need not make scholarship repayments nor will interest accrue during the time he or she is:

1. Engaging in a full-time course of study at an institution of higher education [as defined in 34 CFR 668.2] as verified by the submission of official certification of full-time enrollment by the institution; or

2.-3. (No change.)

4. Unable to secure employment for a period not to exceed 12 months by reason of the care required by a spouse**, child or parent** who is disabled as evidenced by a qualified physician's sworn affidavit; or

5. (No change.)

6. Unable to satisfy the terms of the repayment schedule established by the NJHEAA, and is also seeking and unable to find full-time employment as a teacher in a public or private nonprofit preschool, elementary or secondary school, or [in a public or private nonprofit preschool, elementary or secondary] education program for a single period not to exceed 27 months as evidenced by notarized copies of letters of application for teaching positions and any other documents as required by the Department of Higher Education, Office of Student Assistance[.]**; or**

**7. Satisfying any additional provisions of repayment exceptions that may be prescribed by the U.S. Secretary of Education.**

9:7-9.13 Cancellation of repayment schedule

(a) The Student Assistance Board shall cancel a scholar's repayment obligations if it determines:

1. On the basis of a sworn affidavit of a qualified physician that the scholar is unable to teach on a full-time basis because [of an impairment that is expected to continue indefinitely or result in death.] **he or she is permanently totally disabled; or**

2. (No change.)

9:7-9.14 Determination of postponement or cancellation of repayment schedule

Documentation submitted in support of a request by a scholar for postponement or cancellation of the loan obligation attesting to any of the above conditions shall be reviewed individually by the Department of Higher Education, Office of Student Assistance and final determination will be made by the [Student Assistance Board] **director of the applicable program within the Department of Higher Education.** The final decision will be forwarded to the scholar within 60 days of the written request for postponement or cancellation of the loan obligation.

9:7-9.15 Default

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

(c) The scholar will also be required to pay all charges and other costs, including attorney's fees, for the collection of the defaulted

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amounts. If this loan is referred for collection to an agency that is subject to the Fair Debt Collection Practices Act (15 U.S.C. [sec.] 1692 **as of September 20, 1977 including all subsequent amendments and supplements**), the scholar will pay all reasonable collection costs.

# CORRECTIONS

## (a)

### STATE PAROLE BOARD

### Parole Board Rules

### Board Panel Action; Schedule of Future Parole Eligibility Dates Upon Revocation of Parole

### Proposed Amendment: N.J.A.C. 10A:71-7.16

Authorized By: New Jersey State Parole Board, Mary Keating DiSabato, Chairman.

Authority: N.J.S.A. 30:4-123.48(d).

Proposal Number: PRN 1993-450.

Submit comments by September 15, 1993 to:
Robert M. Egles
Executive Director
New Jersey State Parole Board
CN 862
Trenton, NJ 08625

The agency proposal follows:

**Summary**

Effective November 25, 1992, N.J.S.A. 30:4-123.59(b) was amended to establish as general conditions of parole the requirement that a parolee shall not own or possess any firearm as defined in N.J.S.A. 2C:39-1f; the requirement that a parolee shall not own or possess any other weapon enumerated in N.J.S.A. 2C:39-1r; and the requirement that a parolee shall refrain from the use, possession or distribution of a controlled dangerous substance, controlled substance analog or imitation controlled dangerous substance as defined in N.J.S.A. 2C:35-2 and N.J.S.A. 2C:35-11. Amending N.J.A.C. 10A:71-7.16 to include reference to the aforementioned general conditions effectively establishes the presumptive parole eligibility term to be established by the Board panel upon the revocation of an offender's parole status for violation of one of the general conditions.

**Social Impact**

The proposed amendments will impact on parolees who violate their parole status by failing to comply with the additional general conditions of parole. Upon the implementation and completion of the parole revocation hearing process, the appropriate Board panel will determine whether the offender's parole status shall be revoked. The rendering of a decision to formally revoke the offender's parole status will include the establishment of a future parole eligibility term which must be served before the offender becomes eligible for parole consideration.

**Economic Impact**

The economic impact of the proposed amendments is not easily identifiable. It is, however, anticipated that there will be an increase in the number of formal revocation decisions rendered due to the violating of the additional general conditions of parole. The Department of Corrections will therefore be required to expend funds for the confinement of additional State inmates in State correctional facilities and possibly expend funds to reimburse county jail facilities for the confinement of additional State inmates during the service of the future parole eligibility term established upon the revocation of parole in each offender's case.

**Regulatory Flexibility Statement**

The proposed amendments impose no reporting, recordkeeping or other compliance requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendments pertain to the establishment of future parole eligibility terms upon the revocation of parole statuses for violation of certain general conditions of parole. A regulatory flexibility analysis is, therefore, not required.

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

10A:71-7.16 Board panel action; schedule of future parole eligibility dates upon revocation of parole

(a) (No change.)

(b) Except as provided herein, upon revocation of parole, an adult inmate shall serve 12 months, a young adult inmate shall serve nine months, and a juvenile inmate shall serve six months, if the inmate has committed one of the following violations of parole:

1. (No change.)

2. Owning or possessing [a] **any** firearm, **as defined in N.J.S.A. 2C:39-1f,** for any purpose, N.J.A.C. 10A:71-6.4(a)6.

**3. Owning or possessing any weapon enumerated in N.J.S.A. 2C:39-1r, N.J.A.C. 10A:71-6.4(a)7.**

**4. Failure to refrain from the use, possession or distribution of a controlled dangerous substance, controlled substance analog or imitation controlled dangerous substance as defined in N.J.S.A. 2C:35-2 and N.J.S.A. 2C:35-11, N.J.A.C. 10A:71-6.4(a)8.**

[3.]**5.** (No change in text.)

(c)-(t) (No change.)

# INSURANCE

## (b)

### DIVISION OF THE NEW JERSEY REAL ESTATE COMMISSION

### Real Estate Commission Rules

### Proposed Readoption: N.J.A.C. 11:5

Authorized By: New Jersey Real Estate Commission, Micki Greco Shillito, Executive Director.

Authority: N.J.S.A. 45:15-6.

Proposal Number: PRN 1993-406.

Submit comments by September 15, 1993 to:
Robert J. Melillo
Special Assistant to the Director
New Jersey Real Estate Commission
CN 328
Trenton, NJ 08625-0328

The agency proposal follows:

**Summary**

Pursuant to Executive Order Number 66(1978), N.J.A.C. 11:5 will expire on October 28, 1993. The New Jersey Real Estate Commission (Commission) has reviewed the rules and deems them necessary, reasonable and proper for the purpose for which they were originally promulgated. The Real Estate Commission proposed to readopt these rules, many of which have been amended by the Commission within the last few years.

A summary of the text of the existing subchapters being proposed for readoption follows:

Subchapter 1 includes all of the rules of general application currently promulgated by the Commission. These involve such matters as salesperson's and broker's licensure requirements, the payment of commissions and fees, office maintenance, recordkeeping, removal of files, advertising, contracts of sale, leases and listing agreements, approved schools requirements, instructor qualifications, criminal history record check, proscription of certain discriminatory commission splits, proscriptions on price fixing and collusion in regard to methods of arriving at commissions, and the real estate guaranty fund. It should be noted that many of the rules in this subchapter have been amended in the last few years for the purpose of clarification and to improve their effectiveness. In addition, new rules were promulgated in 1992 imposing disclosure requirements upon licensees who, for a fee, provide financing services to buyer-borrowers in the same transactions in which they also will collect compensation for providing real estate brokerage services. The decision to readopt many of these rules is in part based upon the testimony and comments considered by the Commission during the adoption proceedings on those amendments and new rules.

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Subchapter 2, 3, 4, and 5 include, respectively, recently enacted rules specifying the Commission's organizational structure, the procedures on petitioning the Commission for rulemaking, procedures for hearings and appeals before the Commission, and appeals of initial denials of licensing applications.

Subchapter 6 contains the rules implementing the Real Estate Sales Full Disclosure Act, N.J.S.A. 45:15-16.27 et seq. These rules contain definitions of key terms and address such matters as the form in which applications for registration under the act must be submitted, the contents of such applications and of Public Offering Statements on registered properties, fees, annual reporting requirements, advertising of registered properties and exemption criteria. This entire subchapter became effective in September 1990 after a public hearing and extensive public comment, subsequent to the predecessor statute to the Real Estate Sales Full Disclosure Act having been declared unconstitutional by the federal courts.

Finally it must also be noted that the Real Estate Licensing Law which the Commission administers, N.J.S.A. 45:15-1 et seq., was itself extensively amended and supplemented earlier this year. Many of the substantive changes effected by the passage of that legislation became operative on May 20, 1993. The balance of the revisions to the law, including most of the changes which impact upon licensing procedures, will become effective on July 1, 1994. In order to keep the Commission's rules consistent with the amended law and to implement the new sections added to the law, the Commission will engage in extensive rulemaking in the near future.

**Social Impact**

The readoption of the existing rules will have a beneficial social impact on the real estate industry and the public at large. The rules which set forth the administrative and procedural guidelines concerning commissions, fees, advertising, educational requirements, office maintenance, and the maintenance of employment and escrow or trust account records help the Commission ensure that real estate licensees comply with their statutory obligations when engaging in real estate transactions.

Furthermore, these rules provide valuable information to licensees, consumers and other interested persons who are affected by the administrative policies and actions of the Commission. Through the readoption of these rules, the Commission will continue to provide administrative and managerial direction to real estate licensees through the regulatory process.

**Economic Impact**

The readoption of these rules will have a substantial economic impact on real estate licensees. The requirements regarding termination agreements and accountings of commissions due salespersons (N.J.A.C. 11:5-1.10); the content of advertisements (N.J.A.C. 11:5-1.15); the content of contracts, leases and listing agreements (N.J.A.C. 11:5-1.16); and the sale of interstate properties (N.J.A.C. 11:5-6) established by these rules do impose additional costs of doing business on licensees. Further, the procedures mandated for the maintenance of escrow accounts (N.J.A.C. 11:5-1.8 and 9), the keeping of business and trust account records (N.J.A.C. 11:5-1.11, 12 and 13), the supervision of offices (N.J.A.C. 11:5-1.18 and 19), the closing of offices (N.J.A.C. 11:5-1.24), the operation of prelicensure schools (N.J.A.C. 11:5-1.28), the operation of rental referral agencies (N.J.A.C. 11:5-1.32), the division of compensation in cooperative transactions (N.J.A.C. 11:5-1.33 and 34), and the provisions pertaining to the Real Estate Guaranty Fund (N.J.A.C. 11:5-1.36) all have a substantial economic impact upon licensees' operations.

Several other rules to be readopted operate to lower the costs incurred by licensees. These include the rules on criminal history record checks (N.J.A.C. 11:5-1.29), the sponsoring of applications or transfers of licenses (N.J.A.C. 11:5-1.30), and the expediting of license procedures (N.J.A.C. 11:5-1.31).

The procedural rules, particularly subchapters 3 and 4 help licensees and other persons affected by the rules to identify and prepare for expenses associated with administrative hearings and the filing of pleadings with and appeals to the full Commission.

**Regulatory Flexibility Analysis**

As a result of the readoption of these rules, small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., will not be burdened by any reporting requirements. However, through their readoption some of these rules will continue to impose burdens on all brokerage firms, regardless of size, to keep comprehensive records of many aspects of their operations and to make written disclosure to the parties to real estate transactions in cases where licensees are also providing mortgage services to a borrower in the transaction for a fee. The costs imposed by such requirements are administrative in nature, and will vary with the brokers' operational size and business volume. The Commission does not believe it will be necessary for professional services to be employed to maintain compliance. Although brokers may employ legal and accounting professionals to assist in their operations, as the requirements imposed are an integral part of a broker's daily operation, compliance will most likely be performed by a broker's staff. These requirements are designed to provide adequate safeguards to protect the public interest. Thus, the readoption of such rules as those on the maintenance and production of escrow account records (N.J.A.C. 11:5-1.12 and 13), commissions and accountings to salespersons (N.J.A.C. 11:5-1.10), contracts of sale and listing agreements (N.J.A.C. 11:5-1.16), residential rental referral agencies (N.J.A.C. 11:5-1.32), the providing of mortgage services for a fee (N.J.A.C. 11:5-1.38 through 1.42), and approved schools' student records (N.J.A.C. 11:5-1.28) will benefit all licensees and the public at large. This is true because these rules assure that all licensed real estate brokerage firms and approved schools, as applicable, maintain adequate records of their dealings with the public and with other licensees and make adequate disclosure of their actions on behalf of a party to a transaction other than their principal for compensation.

Generally, the type of small business, as that term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., to which the rules in subchapter 6 apply are small real estate brokerage firms. It is unlikely that many small developers will be required to register their projects because the Act specifically exempts projects of less than 100 lots, parcels, units or interests, unless the project is a condominium, cooperative, timeshare, retirement community or other type of subdivision involving a homeowners association. It is estimated that some 150 New Jersey brokers will be registered as either the brokers of record or as supplemental brokers for registered developers. Most, but not all, of these are small brokerage operations.

The reporting requirements imposed by the Act and the subchapter primarily involve the obligation of reporting to the Commission any material changes in the information previously supplied with an application for registration or renewal, or in the nature of the project or the environmental or financial factors affecting the project. In addition, developers are required to file annual reports updating the Commission on the status of registered projects. The primary recordkeeping requirements involve the proper escrowing of deposit payments and the maintenance of receipts for Public Offering Statements and Brokers Releases provided to prospective purchasers. In addition, copies of contracts signed by such purchasers must be maintained for seven years. Among the other compliance requirements are the obligation to include the registration number and a statement confirming that registration with the Commission does not constitute an endorsement of the project in all advertisements of registered projects.

In order to comply with the requirements of the Act and the subchapter, it is likely that developers would need to retain the services of an accountant and an attorney. As noted above, the initial costs of preparing a registration application could range from $1,000 to $10,000, depending on the size and nature of the project registered. However, these costs would not be incurred by the small business/brokerage firms representing such a project, but rather by the registrant itself. Again, because of the exemption provisions contained in the Act, it is unlikely that many registrants will be small businesses.

It is difficult to estimate the annual cost of compliance because the cost of compliance will vary in direct relation to the number and significance of material changes in the project or in factors affecting the project. If there were no material changes, annual compliance would generally be limited to proper recordkeeping and escrowing of monies, or the maintenance of adequate financial assurances, and the filing of an annual report. However, if there were material changes, compliance would entail the submission of applications for amendments to a registration and/or Public Offering Statement, with attendant costs. However, again, these costs would be incurred by the registrants and not by the brokers representing their projects.

The rules in subchapter 6 are designed to minimize any adverse economic impact on smaller developers by providing for the possibility that such developers could secure a limited exemption, if they did not qualify for a full exemption from the requirements of the Act. Recipients

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of limited exemptions will not be required to file complete registration packages, nor to obtain approval of a New Jersey Public Offering Statement.

Subchapter 6 does not establish different compliance or reporting requirements or timetables based upon the resources available to small businesss. This is true because the statute imposes annual reporting requirements upon all registrants. However, the rules do provide for the issuance of limited exemptions with a duration of two years in an effort to assist smaller developers in complying with the intent of the Act.

For the most part, the rules do utilize performance standards rather than design standards. However, one exception to this may be found in N.J.A.C. 11:5-6.3 where the forms of documents to be included in an application for registration are prescribed.

The rules in subchapter 6 do not go farther in exempting small businesses from the reporting and recordkeeping and other compliance requirements than is evidenced by the limited exemption provisions because the potential threat to the public welfare posed by even limited projects which involve the sale or rental of interests in real estate can involve the payment of substantial funds by prospective purchasers or lessees. In order to safeguard the interests of such prospective purchasers or lessees in such smaller projects, it was necessary to impose many of the same reporting, recordkeeping and compliance requirements on the developers of those projects.

The Commission has concluded that the benefits and protections afforded to the public and to other licensees by the readoption of these rules outweigh the cost of compliance which will be incurred by licensees.

**Full text** of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 11:5.

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# (a)

## SMALL EMPLOYER HEALTH BENEFITS PROGRAM

## Proposed New Rules: N.J.A.C. 11:21

Authorized By: New Jersey Small Employer Health Benefits Program Board, Maureen Lopes, Chairperson.

Authority: N.J.S.A. 17B:27A-17 et seq., as amended by P.L. 1993, c.162, Section 16.

Proposal Number: PRN 1993-458.

A **public hearing** concerning these proposed rules will be held by the Small Employer Health Benefits Board on Wednesday, September 1, 1993 at 9:30 A.M. at the following address:

Mary G. Roebling Building
Second Floor
20 West State Street
Trenton, New Jersey 08625

Submit written comments by September 16, 1993 to:

Interim Administrator
New Jersey Small Employer Health Benefits Program
SEH Box 1
c/o The Prudential Insurance Co. of America
P.O. Box 4080
Iselin, New Jersey 08830

The agency proposal follows:

**Summary**

These rules are being proposed pursuant to the Small Employer Health Benefits Program, P.L. 1992, c.162 enacted November 30, 1992 and amended June 30, 1993, P.L. 1993, c.162 (N.J.S.A. 17B:27A-17 et seq.) ("The Act").

The Small Employer Health Benefits Program ("SEH") Board of Directors ("Board") is promulgating rules in accordance with the procedure set forth in P.L. 1993 c.162, Section 16(a)-(f) which sets forth a procedure which the Board may follow to adopt actions, notwithstanding the provisions of P.L. 1968 c.410 (N.J.S.A. 52:14B-1 et seq.). Section 16 generally provides that prior to the adoption of health benefits plans, the Board shall publish notice of its intended action in three newspapers of general circulation, and mail same to those persons and entities specified in Section 16. The Board is further required to forward the notice of intended action and detailed description to the Office of Administrative Law for publication in the New Jersey Register. The Board is required to hold a public hearing on the establishment and modification of health benefits plans, which hearing has been scheduled by the Board for September 1, 1993. The Board is also required to provide all interested persons an opportunity to comment in writing on the intended action. The Board has established September 16, 1993 as the date by which all written comments must be received. The Board will take final action on these proposed rules immediately following the close of the public comment period, which shall be effective on the date the regulations are submitted to the Office of Administrative Law for publication in the New Jersey Register, or such later date as the Board may establish pursuant to P.L. 1993, c.162, Section 16(e).

In accordance with the Act, insurance companies, health service corporations, hospital service corporations, medical service corporations, health maintenance organizations, and multiple employer arrangements offering health benefits plans for small employers (collectively, "carriers") must offer, as a condition of transacting business in this State, health benefits plans promulgated by the SEH Board. Failure to comply with the requirements of the Act may result in penalty assessments and/or a carrier losing its authority to write any health benefits plans in New Jersey.

The Board is given broad powers to oversee the program including authority to: define the provisions of small employer health benefits plans in accordance with the Act; to promulgate one standard claim form; to promulgate program compliance regulations; and to assess members for operating the program. These rules implement certain provisions of the program defining the health benefits plans and policy forms, optional benefit riders, and standard claim form. The Board is developing additional rules which are necessary to implement the Act and to allow carriers to begin marketing coverage under the program as of January 1, 1994 and which will be promulgated at a later date, and has reserved subchapters for those rules.

Subchapter 1 sets forth the general purpose of Chapter 21, as well as its scope of applicability. This subchapter sets forth general definitions used throughout Chapter 21. (Additional definitions specific to a subchapter are set forth within the separate subchapter.) Subchapter 1 also includes provisions of overall applicability to carriers or to Chapter 21.

Subchapter 3 establishes standard benefit levels of the small employer health benefits plans to be offered as required under the Act.

Subchapter 4 establishes standard policy forms for small employer health benefits plans delivered or issued for delivery in this State on or after the effective date of the Act and in accordance with the Act.

Subchapter 5 establishes a standard claim form that all carriers, to the extent the carrier utilizes claim forms, must use in conjunction with claims arising pursuant to small employer health benefits plans policies sold in accordance with the Act.

Subchapter 2 and subchapters 6 through 18 are reserved for rules to be promulgated.

**Social Impact**

These proposed new rules implement the Act which established the SEH Program under which all small employer carriers in New Jersey must offer standard health benefits plans.

The Board believes that in implementing Chapter 162 through these rules, New Jersey small employers will have access to a greater variety of carriers offering small employer health benefits in the State. The requirement that carriers offer only the health benefits plans designed by the SEH Program Board should enable small employers to readily compare coverage among carriers, and provide assurances that carriers are offering uniform benefits. Carriers in the market are obligated to provide small employer health benefits plans on a guaranteed issue basis.

**Economic Impact**

These proposed new rules will have a substantial economic impact on carriers that offer small employer health benefits plans in this State. Member carriers will be required to bear the costs associated with conforming their present business practices to offer the standard health benefits plans set forth in these rules, to make various filings with the Board, and to pay assessments to the Board. The costs will vary among carriers and member carriers may be required to obtain professional services, including those of actuaries and data systems professionals if such services are not available in-house.

These costs are, however, necessary to implement the comprehensive reforms to the small employer health insurance market set forth in the Act. The costs imposed represent the price of these reforms, and the Board believes that the long-term benefits to carriers and the public will outweigh the costs.

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**Regulatory Flexibility Analysis**

These proposed new rules impose additional recordkeeping, reporting and compliance requirements, as described in the Summary above, for many carriers. The impact will vary among member carriers in accordance with their current practice, but all carriers subject to the rules set forth in this chapter will incur additional costs of compliance.

These rules implement the Act and the proposed rules will affect small business as defined in N.J.S.A. 52:14B-16 et seq. and as defined in the Act. The Act and these implementing rules are advantageous to small businesses because of the requirement that carriers offer five standardized health benefits plans, and therefore standard policies will be available to small employers. This will enable the small employer to more easily compare the premiums charged and service offered by carriers offering health benefits plans. Moreover, the small employers are benefited because of the guarantee issue basis upon which the Act requires the plans to be issued. The small employers are further benefited because of the guaranteed renewability and portability of the benefits plans.

The Board does not believe that any carriers required to comply with these rules are "small businesses" as that term is defined at N.J.S.A. 52:14B-16 et seq. Assuming one or more carriers were small businesses, however, the Board would not be inclined to include any relaxation of these rules, or different compliance requirements, for small businesses. The underlying legislation is intended to establish a limited number of standard health benefits plans for small employers, and to provide a method for regulating small employers health benefits plans in a uniform manner. Different rules applicable to small business carriers would be inconsistent with this clearly stated legislative goal.

**Full text** of the proposed new rules follows:

CHAPTER 21
SMALL EMPLOYER HEALTH BENEFITS PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended by P.L. 1993, c.162 (N.J.S.A. 17B:27A-17 et seq.), the Small Employer Health Benefits Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-17 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Small Employer Health Benefits Program pursuant to N.J.S.A. 17B:27A-17 et seq.

(b) Provisions of the New Jersey Small Employer Health Benefits Act and of this chapter shall be applicable to all carriers that are members of the Small Employer Health Benefits Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Small Employer Health Benefits Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

11:21-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

"Act" means P.L. 1992, c.162 as amended by P.L. 1993, c.162 (N.J.S.A. 17B:27A-17 et seq.), also referred to herein as the Small Employer Health Benefits Plans Act.

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another, except that any insurance company, health service corporation, hospital service corporation, or medical services corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, hospital service corporation or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Board" means the Board of Directors of the New Jersey Small Employer Health Benefits Program established by the Act.

"Carrier" means any insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in New Jersey.

"Cash deductible" means the amount of covered charges that a covered person must pay before the policy pays any benefits for such charges.

"Co-insurance" means the percentage of a covered charge that must be paid by a covered person. Co-insurance does not include cash deductibles, co-payments or non-covered charges.

"Co-insured charge limit" means the amount of covered charges a covered person must incur before no co-insurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the co-insured charge limit.

"Co-payment" means a specified dollar amount a covered person must pay for specified covered charges.

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

"Department" means the New Jersey Department of Insurance.

"Dependent" means the spouse or child of an eligible employee subject to applicable terms of the employee's health benefits plan.

"Doctor" means a medical practitioner who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and

2. Provides medical services which are within the scope of the practitioner's license or certificate and which are covered by policies provided pursuant to this chapter.

"Eligible employee" means a full-time employee who works a normal work week of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 25 hours a week or work on a temporary or substitute basis.

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the Health Maintenance Organization Act of 1973, Pub. L. 93-222 (42 U.S.C. §300e et seq.)

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19). For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.).

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment; has lost coverage under that other employer's health benefits plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; or if a court of competent jurisdiction has ordered coverage to be

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provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

"Medicare" means coverage provided pursuant to Title XVIII of the Federal Social Security Act, Pub. L. 89-97 (42 U.S.C. §1395 et seq.) and amendments thereto.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, whether fully insured or not fully insured, and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"Member" means a carrier that issues health benefits plans in New Jersey on or after November 30, 1992.

"Pre-existing condition" means a policy or contract provision that excludes coverage under that policy or contract for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

"Primary care physician" means a network, or participating, provider who is a doctor specializing in family practice, general practice, internal medicine, obstetrics/gynecology for those services only if applicable, or pediatrics, who supervises, coordinates, arranges and provides initial care and basic care medical services to a member; initiates a member's referral for specialist services; and is responsible for maintaining continuity of patient care.

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to the Act.

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer. Subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of the Act and this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Act and this chapter which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan for small employers approved by the Commissioner pursuant to section 17 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-33).

"State approved HMO" is a health maintenance organization which is approved pursuant to P.L. 1973 c.337 (N.J.S.A. 26:2J-1 et seq.).

SUBCHAPTER 2. (RESERVED)

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

11:21-3.1 Benefits provided

(a) The small employer health benefits plans established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, "The Small Group Health Benefits Basic Policy," Exhibit A;

2. Plan B, "The Small Group Health Benefits Policy B," Exhibit B and Exhibit F;

3. Plan C, "The Small Group Health Benefits Policy C," Exhibit C and Exhibit F;

4. Plan D, "The Small Group Health Benefits Policy D," Exhibit D and Exhibit F;

5. Plan E, "The Small Group Health Benefits Policy E," Exhibit E and Exhibit F;

6. Exhibit F contains those terms of Plans B, C, D and E which are common among the plans; and

7. HMO Plan, "The Small Group Health Maintenance Organization Contract," Exhibit G.

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall only offer all of the health benefits Plans A, B, C, D, and E as set forth in Exhibits A through F, in the Appendix, except as set forth in (c) below.

1. Plans B, C and D shall contain the following annual deductible options to the small employer for each plan:

i. $250.00 per covered person and $500.00 per covered family. The family deductible limit must be satisfied by two separate covered persons;

ii. $500.00 per covered person and $1,000 per covered family. The family deductible limit must be satisfied by two separate covered persons; and

iii. $1,000 per covered person and $2,000 per covered family. The family deductible limit must be satisfied by two separate covered persons.

2. Members offering Plan E shall offer only an annual deductible of $150.00 per covered person and $300.00 per covered family. The family deductible limit must be satisified by two separate covered persons.

(c) State approved and Federally qualified HMO members may offer the HMO Plan, as set forth in Exhibit G of the Appendix, in lieu of Plans A through E in (a) above. HMO members offering the HMO Plan shall offer the following arrangements: $150.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $15.00 co-payment for all other co-payments. Prescription drugs may be subject to 50 percent coinsurance or $15.00 co-payment at HMO member's option. HMO members choosing to offer optional health benefits plans may offer one or more of the following co-payment options, provided that all options offered by the HMO member shall be offered to each small employer:

1. $75.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $5.00 co-payment for all other co-payments;

2. $100.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $10.00 co-payment for all other co-payments; and/or

3. $250.00 hospital inpatient co-payment excluding mental/nervous, substance abuse and alcoholism treatment, $200.00 mental/nervous and substance abuse hospital inpatient co-payment and alcoholism hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $20.00 co-payment for all other co-payments.

(d) The small employer health benefits Plans B, C, D and E and the HMO Plan and optional riders may be offered through or in conjunction with an approved contracting arrangement approved pursuant to P.L. 1993, c.162, Section 22, and shall be subject to the following:

1. The in-network and out-network benefit level differential shall not exceed 30 percent;

2. The co-insured charge limit and deductibles specified for the standard health benefits plan being offered through or in conjunction with a managed care arrangement, as set forth in Exhibits B through

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G in the Appendix, shall be the co-insured charge limit and deductibles for the in-network and out-network benefits combined;

3. The HMO Plan standard co-payment levels for practitioner visits, emergency room and hospital confinements may be substituted for deductibles applicable to in-network benefits and out-network benefits. Where such co-payments are utilized, the applicable deductible and co-insured charge limit shall be applicable only to out-network benefits; and

4. Where in-network services are directed through a primary care physician under Plans B, C, D and E and HMO Plan, in-network services must conform to one of the options provided in (c) above, and out-network services must conform to one of the options provided in (b) above.

(e) The small employer health benefits Plan A may be offered through or in conjunction with a managed care arrangement, and shall be subject to the following:

1. For those services which are subject to 20 percent co-insurance, the in-network benefit shall not be subject to co-insurance; and

2. For those services which are subject to 50 percent co-insurance, the in-network co-insurance shall be 30 percent.

11:21-3.2 Optional benefit riders

(a) Members that offer health benefits Plans B, C, D and E may offer one or more of the optional benefit riders set forth in (c)1 and 2 below. Members that offer the HMO health benefits plan may offer the prescription drug riders set forth in (c)3 below. All riders shall contain the benefits, limitations and exclusions set forth in the Appendix which is incorporated herein by reference and shall be issued in the standard form set forth in the Appendix which is incorporated herein by reference. A member electing to offer an optional benefits rider with a health benefits plan (Plan B, C, D, E or HMO Plan, as applicable) must offer the rider to any employer seeking to purchase that health benefits plan.

(b) Any member electing to offer one or more optional benefits riders shall file a statement identifying the rider(s) to be offered and identifying the health benefits plan(s) with which the rider will be offered. The statement shall be filed with the Board no later than 30 days prior to the date the rider is to be offered to employers, and shall set forth the date on which the carrier proposes to offer such rider(s).

(c) The optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select one or more of the following riders to be offered with each health benefits Plan (Plan B, C, D, or E):

i. Exhibit H, part 1 (mail order and card);

ii. Exhibit H, part 2 (card only); or

iii. Exhibit H, part 3 (mail order only)

2. Replacement mental and nervous conditions and substance abuse benefits, Exhibit I; and

3. Replacement prescription drug benefits for HMO Plans. The carrier may select one or more of the following riders to be offered with the HMO health benefits plan:

i. Exhibit J, part 1 (mail order and card);

ii. Exhibit J, part 2 (card only); or

iii. Exhibit J, part 3 (mail order only).

SUBCHAPTER 4. POLICY FORMS

11:21-4.1 Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D and E which are set forth in the Appendix to this chapter as Exhibits A through F, subject to the "Explanation of Brackets (Plans A, B, C, D)" set forth in Exhibit K, Part 1 of the Appendix, incorporated herein by reference.

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G, subject to the "Explanation of Brackets (HMO Plan)" set forth in Exhibit K, Part 2 of the Appendix, incorporated herein by reference.

(c) In issuing riders pursuant to N.J.A.C. 11:21-3, members shall use the standard rider forms which are set forth in the Appendix to this chapter as Exhibits H, I and J, as applicable.

(d) All health benefits plans and optional benefits riders issued to small employers on and after January 1, 1994 shall be issued in accordance with these rules.

SUBCHAPTER 5. STANDARD CLAIM FORM

11:21-5.1 Standard Claim Form

(a) All members offering health benefits plans to small employers shall, to the extent that the member uses claims forms in its transaction of business, require as a condition of payment, the standard claim form approved by the Board and set forth as Exhibit L in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions, set forth in Exhibit L, Part 1, shall be the standard claim form for all medical expenses incurred for services other than hospital inpatient services. The form UB-82 set forth as Exhibit L, Part 2, shall be the standard claim form for all hospital inpatient services.

(b) If a carrier determines that additional information is necessary of the claimant to process a claim, the carrier shall use the "Annual Family Profile and Claim Notice" form as set forth as Exhibit M and incorporated herein by reference. A carrier shall not use any other form to solicit family profile information of the claimant.

SUBCHAPTERS 6-18. (RESERVED)

**APPENDIX**

**EXHIBIT A**

**PLAN A**
**[Carrier]**

**SMALL GROUP HEALTH BENEFITS BASIC POLICY**

**POLICYHOLDER:** [ABC Company]

**GROUP POLICY NUMBER**
[G-12345]

**GOVERNING JURISDICTION**
NEW JERSEY

**EFFECTIVE DATE OF POLICY**
[January 1, 1994]

**POLICY ANNIVERSARIES:** [January 1st of each year, beginning in 1995.]

**PREMIUM DUE DATES:** [Effective Date, and the first day of the month beginning with February, 1994.]

**AFFILIATED COMPANIES:** [DEF Company]

[Carrier] in consideration of the application for this Policy and of the payment of premiums as stated herein, agrees to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Policy.

The Effective Date is specified above.

This Policy takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

[Secretary President]

[Dividends are apportioned each year.]

**POLICY INDEX**


| SECTION | PAGE(S) |
|---|---|
| Schedule of Insurance and Premium Rates | |
| General Provisions | |
| Claims Provisions | |
| Planholders | |
| Definitions | |
| Employee Coverage | |
| Dependent Coverage | |
| Preferred Provider Organization Provisions | |
| Point of Service Provisions | |

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Health Benefits Insurance .....
Utilization Review Features .....
Alternate Treatment Features .....
Centers of Excellence Features .....
Exclusions .....
Continuation Rights .....
Conversion Rights for Divorced Spouses .....
Effect Of Interaction with a Health Maintenance Organization Plan .....
Coordination of Benefits .....
Benefits for Automobile Related Injuries .....
How This Policy Interacts with Medicare .....
Right To Recovery—Third Party Liability .....
Statement of ERISA Rights .....
Claims Procedures .....

**SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN A**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Calendar Year Cash Deductible:**

| | |
|---|---|
| • for Hospital Confinement | None (Note: See Hospital Confinement Co-Payment) |
| • for Preventive Care | None |
| • for All Other Charges | |
| —per Covered Person | $250 |
| —per Covered Family | $500. Note: Must be individually satisfied by 2 separate Covered Persons |

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

**Hospital Confinement Co-Payment**

| | |
|---|---|
| —per day | $250 |
| —maximum Co-Payment per Period of Confinement | $1,250 |
| —maximum Co-Payment per Covered Person per Calendar Year | $2,500 |

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

| | |
|---|---|
| • for Preventive Care | None |
| • for Facility charges made by: | |
| —a Hospital | 20% |
| —an Ambulatory Surgical Center | 20% |
| —a Birthing Center | 20% |
| —an Extended Care Center or Rehabilitation Center | 20% |
| —a Hospice | 20% |
| • for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital: | |
| —Prescription Drugs | 20% |
| —Blood Transfusions | 20% |
| —Infusion Therapy | 20% |
| —Chemotherapy | 20% |
| —Radiation Therapy | 20% |
| • for all other Covered Charges | 50% |
| **Co-Insurance Cap** per Covered Person per each Calendar Year | $5,000 |

**Daily Room and Board Limits**

**• During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

**• During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

**Pre-Approval** is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

**Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges**

**SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE: PLAN A PPO**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Calendar Year Cash Deductible:**

| | |
|---|---|
| • for Hospital Confinement | None (Note: See Hospital Confinement Co-Payment) |
| • for Preventive Care | None |
| • for All Other Charges | |
| —per Covered Person | $250 |
| —per Covered Family | $500. Note: Must be individually satisfied by 2 separate Covered Persons |

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

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**Hospital Confinement Co-Payment**

| | |
|---|---|
| —per day | $250 |
| —maximum Co-Payment per Period of Confinement | $1,250 |
| —maximum Co-Payment per Covered Person per Calendar Year | $2,500 |

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

| | If treatment, services or supplies are given by a: | |
|---|---|---|
| | **Network Provider** | **Non-Network Provider** |
| The **Co-Insurance** for this Policy is as follows: | | |
| • for Preventive Care | None | None |
| • for Facility charges made by: | | |
| —a Hospital | None | 20% |
| —an Ambulatory Surgical Center | None | 20% |
| —a Birthing Center | None | 20% |
| —an Extended Care Center or Rehabilitation Center | None | 20% |
| —a Hospice | None | 20% |
| • for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital: | | |
| —Prescription Drugs | None | 20% |
| —Blood Transfusions | None | 20% |
| —Infusion Therapy | None | 20% |
| —Chemotherapy | None | 20% |
| —Radiation Therapy | None | 20% |
| • for all other Covered Charges | 70% | 50% |

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Coinsurance is required.

**Coinsured Charge Limit:** $10,000

**Daily Room and Board Limits**

• **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

• **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lessor of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

**Pre-Approval** is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

**Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges**

**Payment Limits:** For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

| | |
|---|---|
| Charges for Inpatient Hospital confinement | 30 days |
| Charges for Home Health Care | exchange basis* for Hospital days |
| Charges for Extended Care or Rehabilitation Center Care | exchange basis* for Hospital days |
| Charges for Hospice Care | exchange basis* for Hospital days |

*See the **Covered Charges** section for a description of the exchange rules.

| | |
|---|---|
| Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance) | |
| —per Covered Person | $100 |
| —per Covered Family | $300 |
| **Per Lifetime Maximum Benefit** (for all Illnesses and Injuries) | $1,000,000 |

**PREMIUM RATES**

[The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

| **Coverage** | **Premium Rate** |
|---|---|
| Health Benefits | |
| —per Employee | $9999.99 |
| —per Employee and spouse | $9999.99 |
| —per Employee and children | $9999.99 |
| —per Employee, spouse and children | $9999.99] |

[Carrier] has the right to change any premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

**GENERAL PROVISIONS**

**THE POLICY**

The entire Policy consists of:

[a. the forms shown in the Policy Index as of the Effective Date;
b.] the Policyholder's application, a copy of which is attached to this Policy;
[c.] any riders, [endorsements] or amendments to this Policy and
[d.] the individual applications, if any, of the persons covered.

**STATEMENTS**

No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:

a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or
b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person or the Covered Person's beneficiary.

All statements will be deemed representations and not warranties.

**INCONTESTABILITY OF THIS POLICY**

There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for 2 years.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

If this Policy replaces the policy of another insurer, [Carrier] may rescind this Policy based on misrepresentations made in the Policyholder's or a Covered Person's signed application for up to two years from this Policy's Effective Date.

**AMENDMENT**

This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]. [Carrier] may also make amendments to this Policy, as provided in b. and c. below. [Carrier] will give the Policyholder

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30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of this Policy; or to extend the time in which a premium may be paid; or to make or change a Policy; or to bind [Carrier] by a promise or representation or by information given or received.

No change in this Policy is valid unless the change is shown in one of the following ways:

[a. It is shown in an endorsement on it signed by an officer of [Carrier].]

[b.] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the **Conformity With Law** section, it is shown in an amendment to it that is signed by an officer of [Carrier].

[c.] In the case of a change required by [Carrier], it is shown in an amendment to it that:

- is signed by an officer of [Carrier]; and
- is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.

[d.] In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

**AFFILIATED COMPANIES**

If the Policyholder asks [Carrier] in writing to include an Affiliated Company under this Policy, and [Carrier] gives written approval for the inclusion, [Carrier] will treat Employees of that company like the Policyholder's Employees. [Carrier's] written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify [Carrier] in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

**PREMIUM AMOUNTS**

The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Policyholder and [Carrier].

The following will apply if one or more premiums paid include premium charges for an Employee whose coverage has ended before the due date of that premium. [Carrier] will not have to refund more than [the amount of a. minus b.:

a. The amounts of the premium charges for such Employee that were included in the premiums paid for the two months period immediately before the date [Carrier] receives written notice from the Policyholder that the Employee's coverage has ended.

b. The amount of any claims paid to an Employee for the Employee's claims or to a member of the Employee's family unit after that person's coverage has ended.]

**PAYMENT OF PREMIUMS—GRACE PERIOD**

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the first time this Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.

**PREMIUM RATE CHANGES**

The premium rates in effect on the Effective Date are shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a. Any premium due date.

b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.

c. Any date that the extent or nature of the risk under this Policy is changed:

- by amendment or this Policy; or
- by reason of any provision of law or any government program or regulation; or
- if this Policy supplements or coordinates with benefits provided by another insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.

d. At the discovery of a clerical error or misstatement as described below.

e. As of the date the nature of the Policyholder's business changes.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

**PARTICIPATION REQUIREMENTS**

If this Policy provides coverage on a Non-contributory basis (the Policyholder pays the entire premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Non-contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or

b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

If this Policy provides coverage on a Contributory basis (the Employee pays part of the premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or

b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

**CLERICAL ERROR—MISSTATEMENTS**

Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will invalidate coverage otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], or the amount of coverage, subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverge is in force under the terms of this Policy, and in what amounts.

**TERMINATION OF THE POLICY—RENEWAL PRIVILEGE**

[Carrier] has the right to cancel this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reasons:

a. During or at End of Grace Period—Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Policyholder may write to [Carrier], in advance, to ask that this Policy be ended

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at the end of the period for which premiums have been paid or at any time during the grace period. Then this Policy will end on the date requested.

b. the Policyholder moves its principal place of business outside the State of New Jersey;

c. subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;

d. with respect to Contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:

1. the Employee is covered as a Dependent under a spouse's coverage; or
2. the Employee is covered under a Health Maintenance Organization plan offered by the Policholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.); or

e. with respect to Non-contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:

1. the Employee is covered as a Dependent under a spouse's coverage; or
2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Policyholder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section.

However, [Carrier] has the right to non-renew this Policy on any Policy Anniversary if the Policyholder is no longer a Small Employer.

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the actions described above as of the Employer's Policy Anniversary.

[Also, if the nature of the Employer's business changes, the Employer must notify [Carrier] within 30 days. [Carrier] has the right to change the rates [Carrier] charges for this Policy if this happens. If the Employer fails to notify [Carrier] within 30 days, [Carrier] has the right to adjust premium rates retroactively to the date the nature of the Employer's business changed.] **[Note: This section will sunset January 1, 1997]**

**[DIVIDENDS**

[Carrier] will determine the share, if any, of its divisible surplus allocable to this Policy as of each Policy Anniversary, if this Policy stays in force by the payment of all premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under this Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

**EMPLOYEE'S CERTIFICATE**

[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:

(1) to whom [Carrier] pays benefits,

(2) any protection and rights when the coverage ends and

(3) claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

**OFFSET**

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

**CONTINUING RIGHTS**

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under this Policy.

**ASSIGNMENT BY POLICYHOLDER**

Assignment or transfer of the interest of the Policyholder under this Policy will not bind [Carrier] without [Carrier's] written consent thereto.

**CONFORMITY WITH LAW**

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

**LIMITATION OF ACTIONS**

No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

**WORKERS' COMPENSATION**

The health benefits provided under this Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

**NOTICES AND OTHER INFORMATION**

Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid, addressed as follows:

If to [Carrier]: To the last address on record with the Policyholder.

If to a Covered person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to [Carrier].

If to the Policyholder: To the last address of the Policyholder on record with [Carrier].

**RECORDS—INFORMATION TO BE FURNISHED**

[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by [Carrier], the Policyholder will send the data required by [Carrier] to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder and of the Employer which bear on this Policy must be open to [Carrier] for its inspection at any reasonable time.

[Carrier] will not have to perform any duty that depends on such data before it is received in a form that satisfies [Carrier]. The Policyholder may correct wrong data given to [Carrier], if [Carrier] has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish [Carrier] the Employee and Dependents eligibility requirements of this Policy that apply on the Effective Date. Subject to [Carrier's] approval, those requirements will apply to the Employee and Dependent coverage under this Policy. The Policyholder will notify [Carrier] of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee or Dependent coverage under this Policy unless approved in advance by [Carrier].

The Policyholder will notify [Carrier] of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of [Carrier] to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. [If the Policyholder fails to notify [Carrier] as provided above, [Carrier] will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person's coverage has ended.]

**CLAIMS PROVISIONS**

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

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[NOTICE OF LOSS

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [Carrier] may honor such direction at [Carrier's] option. The Employee may not assign his or her right to take legal action under this Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

An Employee cannot bring a legal action against this Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against this Policy after three years from the date he or she files proof of loss.

[PLANHOLDERS

The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

**How an Employer becomes a Planholder**

An Employer must submit a signed application in which he:

- agrees to participate in the trust, and
- applies for the insurance provided by this Policy for his Employees.

**When an Employer becomes a Planholder**

The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

**When an Employer ceases to be a Planholder**

The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

**Data needed**

The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[**Note:** This text, which may be modified by each carrier in order to accommodate various trust agreements, is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

DEFINITIONS

**The words shown below have special meanings when used in this Policy. Please read these definitions carefully. [Throughout this Policy, these defined terms appear with their initial letter capitalized.]**

**Actively at Work** or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

**Alcohol Abuse** means abuse of or addiction to alcohol.

**Ambulance** means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

**Ambulatory Surgical Center** means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

**Anniversary Date** means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

**Affiliated Company** means a corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets.

**Birthing Center** means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

**Board** means the Board of Directors of the New Jersey Small Employer Health Program.

**Calendar Year** means each successive 12 month period which starts on January 1 and ends on December 31.

**Cash Deductible** means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. See the **The Cash Deductible** section of this Policy for details.

**Co-Insurance** means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

**Co-Payment** means a specified dollar amount a Covered Person must pay for specified Covered Charges.

**Covered Charges** are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

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A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

**Covered Person** means an eligible Employee or a Dependent who is insured under this Policy.

**Current Procedural Terminology** (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

**Custodial Care** means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

**Dependent** means an Employee's:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. his or her unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children.
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

**Diagnostic Services** means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Coverage Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

**Discretion** means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and nondiscriminatory manner.

**Durable Medical Equipment** is equipment which:

a. is designed and able to withstand repeated use;
b. is primarily and customarily used to serve a medical purpose;
c. is generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. is suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

**Effective Date** means the date on which coverage begins under this Policy for the Employer, or the date coverage begins under this Policy for an Employee or Dependent, as the context in which the term is used suggests.

**Employee** means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility.

**Employer** means [ABC Company].

**Experimental or Investigational** means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

**Extended Care Center** means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

**Facility** means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

**Full-Time** means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

**Generic Drug** means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing

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less. The equivalent must be identical in strength and form as required by the FDA.

**Government Hospital** means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

**Home Health Agency** means a Provider which mainly provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

**Hospice** means a Facility which mainly provides palliative and supportive care for terminally ill people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or
b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

**Hospital** means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission or
b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

**Illness** means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

**Initial Dependent** means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

**Injury** means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

**Inpatient** means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility.

**Joint Commission** means the Joint Commission on the Accreditation of Health Care Facilities.

**Late Enrollee** means an eligible Employee or Dependent who requests enrollment under this Policy more than 30 days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** sections of this Policy.

**Medical Emergency** means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

**Medically Necessary and Appropriate** means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c. in accordance with accepted medical standards in the community at the time;
d. not for the convenience of a Covered Person;
e. the most appropriate level of medical care the Covered Person needs;
f. accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
g. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

**Medicaid** means the health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

**Medicare** means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the Social Security Act, as amended from time to time.

**Mental and Nervous Condition** means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

**Newly Acquired Dependent** means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

**Non-Covered Charges** are charges which do not meet this Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

**Nurse** means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

**Outpatient** means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

**Per Lifetime** means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption.

**Period of Confinement** means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

[**Note:** This definition is needed only for Plan B.]

**Plan** means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

**Planholder** means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

**Podiatric Care** means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

**Policy** means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

**Policyholder** means the Employer who purchased this Policy.

**Practitioner** means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

**Pre-Approval or Pre-Approved** means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

**Pre-Existing Condition** means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

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b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

**Prescription Drugs** are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

**Preventive Care** means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

**Provider** means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

**Reasonable and Customary** means an amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board. When [Carrier] decides what is reasonable, it looks at the Covered Person's condition and how severe it is. [Carrier] also looks at special circumstances. The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the range of usual fees charged by most Providers of similar training and experience for the same service within the same geographic area.

**Rehabilitation Center** means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b. approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

**Routine Foot Care** means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot stain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

**Routine Nursing Care** means the nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

**Schedule** means the **Schedule of Insurance and Premium Rates** contained in this Policy.

**Skilled Nursing Care** means services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

**Skilled Nursing Center** (see Extended Care Center).

**Small Employer** means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

**Special Care Unit** means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a. intensive care units;
b. cardiac care units;
c. neonatal care units; and
d. burn units.

**Substance Abuse** means abuse of or addiction to drugs.

**Surgery** means:

a. the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;
b. the correction of fractures and dislocations;
c. Reasonable and Customary pre-operative and post-operative care; or
d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

**Therapeutic Manipulation** means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the inpingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydro therapy or other treatment of similar nature.

**Total Disability or Totally Disabled** means, except as otherwise specified in this Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[**We, Us, Our** and [**Carrier**] mean [Carrier].]

[**You, Your and Yours** mean the Employer.]

## EMPLOYEE COVERAGE

### Eligible Employees

Subject to the **Conditions of Eligiblity** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

### Conditions of Eligibility

### Full-Time Requirement

[Carrier] will not insure an Employee unless the Employee is an Actively at Work Full-Time Employee.

### Enrollment Requirement

If an Employee must pay part of the cost of Employee Coverage, [Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments. If the Employee does this:

a. more than 30 days after the Employee first becomes eligible; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under this Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee must enroll under this Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

### [The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete 3 months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete 3 months of continuous Full-Time service with the Employer.]

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**Multiple Employment**

If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one firm Employs the Employee. And such an Employee will not have multiple coverage under this Policy. But, if this Policy uses the amount of an Employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

**When Employee Coverage Starts**

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The scheduled Effective Date of an Employee's coverage is as follows:

a. If an Employee must pay part of the cost of Employee coverage, then he or she must elect to enroll and agree to make the required payments within 30 days of his or her eligibility date. If he or she does this within 30 days of his or her eligibility date, his or her coverage is scheduled to start on his or her eligibility date.
b. On non-contributory plans, subject of all the terms of this plan, an Employee's coverage starts on his or her eligibility date.

**When Employee Coverage Ends**

An Employee's insurance under this Policy will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. [the date] an Employee stops being an eligible Employee under this Policy.
c. the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d. the last day of the period for which required payments are made for the Employee.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Policy's benefits provisions explain these situations. Read this Policy's provisions carefully.

**DEPENDENT COVERAGE**

**Eligible Dependents for Dependent Health Benefits**

An Employee's eligible Dependents are:

a. the Employee's legal spouse;
b. the Employee's unmarried Dependent children who are under age 19; and
c. the Employee's unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children,
b. his or her step-children if such step-children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

**Incapacitated Children**

An Employee may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past this Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Policy's age limit;
b. the child became insured by this Policy before the child reached the age limit, and stayed continuously insured until reaching such limit; and
c. the child depends on the Employee for most of their support and maintenance.

But, for the child to stay eligible, the Employee must send [Carrier] written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

**Enrollment Requirement**

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:

a. enrolls a Dependent and agrees to make the required payments after the end of the enrollment period;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Policy because they were covered under another group plan, and the Employee now elects to enroll them in this Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur.

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Policy, to be a Late Enrollee, if:

a. the Employee is under legal obligation to provide coverage due to a court order; and
b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date he or she becomes eligible.

**When Dependent Coverage Starts**

In order for an Employee's dependent coverage to begin the Employee must already be insured for Employee coverage or enroll for Employee and Dependent Coverage at the same time. Subject to the **exception** stated below and to all of the terms of this Policy, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this on or before the Employee's eligibility date, the Dependent's Coverage is scheduled to start on the later of:

a. the Employee's eligibility date, or
b. the date the Employee becomes insured for Employee coverage.

If the Employee does this within or after the enrollment period, the coverage is scheduled to start on the later of:

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a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes insured for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify [Carrier] of a Newly Acquired Dependent within the enrollment period. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b. the date the Newly Acquired Dependent is first eligible.

**Exception:** If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

**Newborn Children**

[Carrier] will cover an Employee's newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

**When Dependent Coverage Ends:**

A Dependent's insurance under this Policy will end on the first of the following dates:

a. [the date] Employee coverage ends;
b. the date the Employee stops being a member of a class of Employees eligible for such coverage;
c. the date this Policy ends;
d. the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class.
e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.
f. the date the Dependent stops being an eligible Dependent. This happens at 12:01 a.m. on the date:
   - the child attains the Policy's age limit;
   - the Dependent child marries;
   - a step-child is no longer dependent on the Employee for support and maintenance;
   - a spouse's marriage ends in legal divorce or annulment.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.

**PREFERRED PROVIDER ORGANIZATION PROVISIONS**

**The Employer, XYZ Health Care Network, and the [Carrier]**

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of this Policy. The Employee should read his or her certificate carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If an Employee has any questions after reading his or her Certificate, he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card].

[**Note:** Used only if coverage is offered as a PPO.]

**POINT OF SERVICE PROVISIONS**

**Definitions**

a. ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of Practitioners who are members of the [XYZ] Provider Organization to the Covered Person.

b. ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.

c. ***Network Benefits*** means the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d. ***Out-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e. ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

**Provider Organization (PO)**

The Provider Organization for this Policy is the [XYZ] Provider Organization. This Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

**The Primary Care Physician (PCP)**

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person **must** obtain an authorized referral from his or her PCP **before** he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she will not be eligible for Network Benefits.

[Carrier] pays Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, Out-Network Benefits will be provided.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

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**Out-Network Services**

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, Out-Network Benefits will be paid.

**Emergency Services**

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room vists to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the Service Area of the EPO.

**Utilization Review**

This Policy has utilization features. See the **Utilization Review Features** section of this Policy.

**Benefits**

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of this Policy.

[**Note:** Used only if coverage is issued as POS.]

**HEALTH BENEFITS INSURANCE**

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

**Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.**

**BENEFIT PROVISION**

**The Cash Deductible**

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

**Family Deductible Limit**

This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.

**Co-Insurance Cap**

This Policy limits Co-Insurance amounts each Calendar Year **except** as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;
b. Cash Deductibles; and
c. Co-Payments.

There is Co-Insurance Cap for each Covered Person.

The Co-Insurance Cap is shown in the Schedule.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.

**Payment Limits**

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

**Benefits From Other Plans**

The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **How This Policy Interacts With Medicare** section for an explanation of how this works.

**If This Plan Replaces Another Plan**

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which this Policy starts;
b. this Policy would have paid benefits for the charges, if this Policy had been in effect;
c. the Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d. this Policy starts right after the old plan ends.

**Extended Health Benefits**

If this Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under this Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of this Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or
b. one year from the date the person's insurance under this Policy ends; or
c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

**COVERED CHARGES**

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

**Charges while Hospitalized**

[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a. Hospital room and board
b. Routine Nursing Care
c. Prescription Drugs
d. Blood transfusions
e. Infusion Therapy
f. Chemotherapy
g. Radiation Therapy
h. Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review

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features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

**Note:** [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care and Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

**Hospital Co-Payment Requirement**

Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Co-Payment for each day of confinement, up to a maximum of $1,250 per confinement, subject to a maximum $2,500 Co-Payment per Calendar Year.

**Testing Charges**

[Carrier] covers x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

**Extended Care and Rehabilitation Charges**

Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 2 days of a Hospital stay; and
b. be due to the same or a related condition that necessitated the Hospital stay.

**Extended Care and Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

**Home Health Care Charges**

Subject to [Carrier's] Pre-Approval, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Policy and to the following conditions:
   a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   b. The services and supplies must be:
      - ordered by the Covered Person's Practitioner;
      - included in the home health care plan; and
      - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

   The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.
   c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once very 60 days.
   d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
   e. [Carrier] does not pay for:
      - services furnished to family members, other than the patient; or
      - services and supplies not included in the home health care plan.

**Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

**Practitioner's Charges for Non-Surgical Care and Treatment**

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury.

**Practitioner's Charges for Surgery**

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

**Second Opinion Charges**

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b. are not business associates of the Practitioner who recommended the Surgery; and
c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

**Ambulatory Surgical Center Charges**

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

**Hospice Care Charges**

Subject to [Carrier] Pre-Approval, when Hospice Care can take the place of Inpatient Hospital Care, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness.

"Terminally ill" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

**Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

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**Pregnancy**

This Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

**Birthing Center Charges**

[Carrier] covers Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

**Benefits for a Covered Newborn Child**

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

Subject to all of the terms of this Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

**Anesthetics**

[Carrier] covers anesthetics and their administration.

**COVERED CHARGES WITH SPECIAL LIMITATIONS**

**The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any 30 day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE and DEPENDENT COVERAGE sections to determine if a Covered Person is a Late Enrollee.**

**Pre-Existing Conditions**

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by this Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

**Continuity of Coverage**

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in this Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

**Private Duty Nursing Care**

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

**Therapy Services**

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.

b. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

[Carrier] covers the therapy Services listed below but **only** when provided on an Inpatient basis.

c. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

d. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

e. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

f. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

g. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

h. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.

Coverages for Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per Calendar Year.

i. *Infusion Therapy*—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

**Preventive Care**

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person $300 per Covered Family.

**IMPORTANT NOTICE**

This Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's Office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or
b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.

This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.

This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.

What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

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If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

UTILIZATION REVIEW FEATURES

**Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.**

Compliance with this policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;
b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

**Definitions**

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

**Grievance Procedure**

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]

REQUIRED HOSPITAL STAY REVIEW

**Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.**

**Notice of Hospital Admission Required**

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

**Pre-Hospital Review**

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission
b. the anticipated length of stay and
c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

**Emergency Admission**

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;
b. the Covered Person group plan number;
c. the reason for the admission;
d. the name and location of the Hospital;
e. when the admission occurred; and
f. the name of the Covered Person's Practitioner.

**Continued Stay Review**

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

**Penalties for Non-Compliance**

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges, **by 50%** if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges **by 50%**, if:

a. [ABC] is not notified of the admission at the times and in the manner described above; or
b. the Covered Person does not request a continued stay review.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends **by 50%** as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:

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a. Cash Deductible; or
b. Co-Insurance Caps.

REQUIRED PRE-SURGICAL REVIEW

**Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.**

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person, or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

**Required Second Surgical Opinion**

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from a Practitioner on the list, or from a Practitioner of his or her own choosing, if the Practitioner:
a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or co-Insurance.

**Pre-Hospital Review**

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

**Penalties for Non-Compliance**

As a penalty for non-compliance, [Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%** if:
a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d. [ABC] does not confirm the need for Surgery.

But there is no penalty when the additional opinions do not confirm the need for the Surgery, and the Surgery is done anyway.

Penalties cannot be used to meet this Policy's:
a. Cash Deductible; or
b. Co-Insurance Caps.

ALTERNATE TREATMENT FEATURES

**Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].**

**Definitions**

"Alternate Treatment" means those services and supplies which meet both of the following tests:
a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b. Benefit for charges incurred for the services and supplies would not otherwise by payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:
a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

**Alternate Treatment Plan**

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes;
a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - [DEF]
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and per lifetime maximums.

**Exclusion**

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.

CENTERS OF EXCELLENCE FEATURES

**Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.**

**Definitions**

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

**Covered Charges**

In order for charges to be Covered Charges, the Center of Excellence must:

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a. perform a Pre-Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]

EXCLUSIONS

**Payment will not be made for any charges incurred for or in connection with:**

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Care or treatment of ***alcohol abuse.***

Services for ***ambulance*** for transportation.

***Blood or blood plasma*** which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

***Completion of claim forms.***

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in this Policy, unless it is required as a result of an Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

***Dental care*** or treatment, including appliances.

Charges made by a ***dialysis center*** for dialysis services.

***Durable Medical Equipment***

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

***Experimental or Investigational*** treatments, procedures, hospitalizations, drugs, biological products or medical devices.

***Extraction of teeth,*** except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lense; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Care and or treatment to enhance ***fertility*** using artificial and surgical drugs and procedures, including, but not limited to, invitro fertilization, invivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to ***Hearing aids, hearing examinations*** or fitting of hearing aids.

Services or supplies related to ***Herbal medicine.***

Care or treatment by means of ***high dose chemotherapy.***

Services or supplies related to ***Hypnotism.***

Services or supplies because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit a felony.

***Illness*** or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

***Local anesthesia*** charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for ***Mental and Nervous Conditions and Substance Abuse.***

***Membership costs*** for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate.

***Non-prescription drugs*** or supplies, except insulin needles and syringes.

Services provided by a licensed ***pastoral counselor*** in the course of his or her normal duties as a religious.

***Personal convenience*** or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

***Podiatric care.***

***Practitioner visits,*** except as stated in the Preventive Care section of this Policy.

***Prescription Drugs*** obtained while not confined in a Hospital on an Inpatient basis.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care,*** except as provided under the Home Health Care section of this Policy.

***Prosthetic Devices.***

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

Services or supplies related to ***rest or convalescent cures.***

***Room and board charges*** for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

***Self-administered services*** such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker,*** except as otherwise stated in this Policy.

***Services or supplies:***

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Covered Person would not have been charged if he or she did not have health care coverage;
d. provided by or in a government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury;

***Smoking cessation*** aids of all kinds and the services of stop-smoking providers.

***Stand-by services required by a Provider.***

***Sterilization reversal***—services and supplies rendered for reversal of sterilization.

***Surgery,*** sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

***Telephone consultations.***

***Therapeutic Manipulation.***

***Transplants.***

***Transportation;*** travel.

***Vision therapy.***

***Vitamins and dietary supplements.***

Services or supplies received as a result of a ***war,*** delcared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

***Weight reduction or control,*** unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

***Wigs, toupees, hair transplants, hair weaving or any drug*** used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

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A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this Policy's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under both this Policy's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

## AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

**The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:**

**a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, and therefore;**
**b. the section applies to the Employee.**

## COBRA CONTINUATION RIGHTS

### Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Poilcy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Policy during a continuation provided by this section is not qualified continuee.

### If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:

a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

### Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

### If An Employee Dies While Insured

If an Employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

### If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

### If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

### Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. The Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

### The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

### The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue this Policy's group health benefits;
b. The monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hour; or
b. the date a qualfied continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

### The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. The Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. The Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

### Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

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The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

**Grace in Payment of Premiums**

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

**When Continuation Ends**

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date this Policy ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this policy's **Conversion Rights for Divorced Spouses** section for details.

**NEW JERSEY GROUP CONTINUATION RIGHTS**

**Important Notice**

This section applies only to group health benefits. This section does not apply to any other coverages provided by this Policy.

**If An Employee's Group Benefits End**

If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

**What The Employee Must Do**

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Policy on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

**The Continued Coverage**

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Policy on a regular basis. Any modifications made under this Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for an Employee to continue.

**When Continuation Ends**

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Covered Person becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Covered Person becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person.
e. with respect to a Covered Person who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing condition of the Covered Person, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Policy.

**A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS**

**If An Employee is Totally Disabled**

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

**How And When To Continue Coverage**

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

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**When This Continuation Ends**

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying;
b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

**AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE**

**Important Notice**

**This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:**

- **the Employer must allow for a leave of absence under Federal law and, therefore**
- **the section applies to the Employee.**

**If An Employee's Group Health Coverage Ends**

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

**When Continuation Ends**

Insurance may continue until the earliest of:

a. the date the Employee returns to Full-Time work
b. the end of a total period of 12 weeks in any 12 month period, or
c. the date on which the Employee's coverage would have ended had the Employee not been on leave.

**A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS**

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Policy.

**CONVERSION RIGHTS FOR DIVORCED SPOUSES**

**IF AN EMPLOYEE'S MARRIAGE ENDS**

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health coverage ends. See **exceptions** below.

**Exceptions**

No former spouse may use this conversion right:

- unless he or she has been insured under this Policy for at least 3 months;
- if he or she is eligible for Medicare; or
- if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

**HOW AND WHEN TO CONVERT**

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

**THE CONVERTED POLICY**

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health coverage under this Policy ends.

After group health coverage under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.

**EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN**

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the medical care benefits provided by this Policy. If the Employer does, the following provisions apply.

**IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP**

**Date Medical Care Insurance Ends**

Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

**Benefits After Medical Care Insurance Ends**

When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

**Exception:**

**IF**, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

**AND** the HMO provides benefits for total disability when membership ends

**THEN** medical care benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

**IF AN HMO MEMBER ELECTS MEDICAL CARE INSURANCE PROVIDED BY THIS POLICY**

**Date Transfer To Such Insurance Takes Effect**

Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

**request made during an open enrollment period**

[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

**request made because:**

- **an HMO ends its operations**
- **Employee moves outside the HMO service area**

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

**request made because an HMO becomes insolvent**

If an Employee requests insurance because membership ends for this reason, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made

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- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

**request made at any other time**

An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

**Other Provisions Affected By A Transfer**

If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

**Charges not covered**

Charges incurred before a person becomes insured will not be considered Non-Covered Charges.

**Maximum benefit**

The total amount of benefits to be paid for each person will be the maximum benefit specified in this Policy, regardless of any interruption in such person's insurance under this Policy.

**Right to change premium rates**

[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

**COORDINATION OF BENEFITS**

**Important Notice**

This provision applies to all health expense benefits under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

**Purpose Of This Provision**

An Employee may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

**DEFINITIONS**

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. group or group-type hospital indemnity benefits which exceed $150.00 per day.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordiante with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits of $150.00 per day or less; and
d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

**How This Provision Works**

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.
    - When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
    - If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
    - The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

**[Carrier's] Right to Certain Information**

In order to coordinate benefits, [Carrier] needs certain information. An Employee must supply [Carrier] with as much of that information as he or she can. But if he or she cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If

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[Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

**Small Claims Waiver**

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

**BENEFIT FOR AUTOMOBILE RELATED INJURIES**

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related injury.

**Definitions**

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian; caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. this Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

**Determination of primary or secondary coverage.**

This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

**Benefits this Policy will pay if it is primary to PIP or OSAIC.**

If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Policy will apply if:

- the Covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

**Benefits this Policy will pay if it is secondary to PIP or OSAIC.**

If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the benefits that would have been paid if this Policy had been primary.

**Medicare**

If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

**HOW THIS POLICY INTERACTS WITH MEDICARE**

**IMPORTANT NOTICE**

**The following section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:**

- **the Employer is subject to the How This Plan Interacts with Medicare section and therefore;**
- **the section applies to the Employee**

The following provisions explain how this plan's group health benefits interact with the benefits available under Medicare. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as shown below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the Social Security Act, as amended from time to time.
b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense."

[d. "We" means Carrier]

**MEDICARE ELIGIBILITY BY REASON OF AGE**

**Applicability**

This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

**When An Employee or Insured Spouse Becomes Eligible For Medicare**

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)—The Medicare eligible may choose this Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Policy is Primary** section below, for details.

Option B—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

**When this Policy is primary**

When a Medicare eligible chooses this Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

**When Medicare is primary**

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

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**MEDICARE ELIGIBILITY BY REASON OF DISABILITY**

**Applicability**

This section applies to a Covered Person who is:

a. under age 65; and

b. eligible for Medicare by reason of End Stage Renal Disease.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or

b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

**When a Covered Person Becomes Eligible for Medicare**

When a Covered Person becomes eligible for Medicare by reason of disability, this Policy supplements the benefit provided by Medicare.

If the disabled Medicare incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, [Carrier] subtracts what Medicare pays from what [Carrier] normally pays.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

**MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE**

**Applicability**

This section applies to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as an "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

**When a Covered Person Becomes Eligible for Medicare Due to ESRD**

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and

b. with respect to an ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, [Carrier] supplements what Medicare pays. [Carrier] subtracts what Medicare pays from what [Carrier] normally pays. If a Covered Person is eligible for Medicare solely on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

**RIGHT TO RECOVERY—THIRD PARTY LIABILITY**

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers, fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;

b. a satisfied judgment; or

c. other means

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier] However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or

b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

**STATEMENT OF ERISA RIGHTS**

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA), ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.

b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contract the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

**CLAIMS PROCEDURE**

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

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In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.
b. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.
c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:
   - the specific reason(s) the claim is denied;
   - specific references to the pertinent plan provision on which the denial is based;
   - a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
   - and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing. [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

## EXHIBIT B

### SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN B]

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Calendar Year Cash Deductible**

| | |
|---|---|
| Per Covered Person | [$250, $500 or $1,000] |
| Per Covered Family | [$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons |

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

**Hospital Confinement Co-Payment**

| | |
|---|---|
| —per day | $200 |
| —maximum Co-Payment per Period of Confinement | $1,000 |
| —maximum Co-Payment per Covered Person per Calendar Year | $2,000 |
| —**Emergency Room Co-Payment,** (waived if admitted within 24 hours) | $50 |

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

| | |
|---|---|
| The **Co-Insurance** for this Policy is as follows: | 40% |

**Co-Insurance Caps**

| | |
|---|---|
| Per Covered Person per each Calendar Year | $3,000 |
| Per Covered Family per each Calendar Year | $6,000. **Note:** Must be individually satisfied by 2 separate Covered Persons |

**Daily Room and Board Limits**

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

**Pre-Approval** is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

**Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges**

**Payment Limits:** For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

| | |
|---|---|
| Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits) | 120 days |
| Charges for manipulation, or adjustment of the spine, per Calendar Year | 30 visits |
| Charges for speech and cognitive therapy per Calendar Year (combined benefits) | 30 visits |
| Charges for physical or occupational therapy per Calendar Year (combined benefits) | 30 visits |
| Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance) | |
| • for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1 | $500 per Covered Person |
| • for all other Covered Persons | $300 per Covered Person |
| Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year | $5,000 |
| Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime | $25,000 |
| **Per Lifetime Maximum Benefit** (for all Illnesses and Injuries) | $1,000,000 |

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## EXHIBIT C

**SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN C]**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Calendar Year Cash Deductible**

| | |
|---|---|
| Per Covered Person | [$250, $500 or $1,000] |
| Per Covered Family | [$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons |

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

| | |
|---|---|
| **Emergency Room Co-Payment,** (waived if admitted within 24 hours) | $50 |

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

| | |
|---|---|
| The **Co-Insurance** for this Policy is as follows: | 30% |

**Co-Insurance Caps**

| | |
|---|---|
| Per Covered Person per each Calendar Year | $2,500 |
| Per Covered Family per each Calendar Year | $5,000 **Note:** Must be individually satisfied by 2 separate Covered Persons |

**Daily Room and Board Limits**

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

**Pre-Approval** is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

**Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges**

**Payment Limits:** For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

| | |
|---|---|
| Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits) | 120 days |
| Charges for manipulation, or adjustment of the spine, per Calendar Year | 30 visits |
| Charges for speech and cognitive therapy per Calendar Year (combined benefits) | 30 visits |
| Charges for physical or occupational therapy per Calendar Year (combined benefits) | 30 visits |
| Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance) | |
| • for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1 | $500 per Covered Person |
| • for all other Covered Persons | $300 per Covered Person |
| Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year | $5,000 |
| Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime | $25,000 |
| **Per Lifetime Maximum Benefit** (for all Illnesses and Injuries) | Unlimited |

## EXHIBIT D

**SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN D]**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Calendar Year Cash Deductible**

| | |
|---|---|
| Per Covered Person | [$250, $500 or $1,000] |
| Per Covered Family | [$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons |

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

| | |
|---|---|
| **Emergency Room Co-Payment,** (waived if admitted within 24 hours) | $50 |

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This

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Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

| | |
|---|---|
| The **Co-Insurance** for this Policy is as follows: | 20%, **except as stated below** |
| **Exception:** for Mental and Nervous and Substance Abuse charges | 25% |

**Co-Insurance Caps**

| | |
|---|---|
| Per Covered Person per each Calendar Year | $2,000 |
| Per Covered Family per each Calendar Year | $4,000. **Note:** Must be individually satisfied by 2 separate Covered Persons |

**Daily Room and Board Limits**

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

**Pre-Approval** is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

**Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges**

**Payment Limits:** For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

| | |
|---|---|
| Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits) | 120 days |
| Charges for manipulation, or adjustment of the spine, per Calendar Year | 30 visits |
| Charges for speech and cognitive therapy per Calendar Year (combined benefits) | 30 visits |
| Charges for physical or occupational therapy per Calendar Year (combined benefits) | 30 visits |
| Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance) | $300 per Covered Person |
| Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year | $5,000 |
| Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime | $25,000 |
| **Per Lifetime Maximum Benefit** (for all Illnesses and Injuries) | Unlimited |

**EXHIBIT E**

**SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN E]**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Calendar Year Cash Deductible**

| | |
|---|---|
| Per Covered Person | $150 |
| Per Covered Family | $300. Note: Must be individually satisfied by 2 separate Covered Persons |

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

| | |
|---|---|
| **Emergency Room Co-Payment,** (waived if admitted within 24 hours) | $50 |

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

| | |
|---|---|
| The **Co-Insurance** for this Policy is as follows: | 10% |

**Co-Insurance Caps**

| | |
|---|---|
| Per Covered Person per each Calendar Year | $1,500 |
| Per Covered Family per each Calendar Year | $3,000 **Note:** Must be individually satisfied by 2 separate Covered Persons |

**Daily Room and Board Limits**

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

**Pre-Approval** is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation

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- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

**Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges**

**Payment Limits:** For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

| | |
|---|---|
| Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits) | 120 days |
| Charges for manipulation, or adjustment of the spine, per Calendar Year | 30 visits |
| Charges for speech and cognitive therapy per Calendar Year (combined benefits) | 30 visits |
| Charges for physical or occupational therapy per Calendar Year (combined benefits) | 30 visits |
| Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance) | $300 per Covered Person |
| Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year | $5,000 |
| Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime | $25,000 |
| **Per Lifetime Maximum Benefit** (for all Illnesses and Injuries) | Unlimited |

**EXHIBIT F**

**PLANS B, C, D, E**

**[Carrier]**

**SMALL GROUP HEALTH BENEFITS POLICY**

**POLICYHOLDER:** [ABC Company]

**GROUP POLICY NUMBER**
[G-12345]

**GOVERNING JURISDICTION**
NEW JERSEY

**EFFECTIVE DATE OF POLICY**
[January 1, 1994]

**POLICY ANNIVERSARIES:** [January 1st of each year, beginning in 1995.]

**PREMIUM DUE DATES:** [Effective Date, and the first day of the month beginning with February, 1994.]

**AFFILIATED COMPANIES:** [DEF Company]

[Carrier] in consideration of the application for this Policy and of the payment of premiums as stated herein, agrees to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Policy. The Effective Date is specified above.

This Policy takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

[Secretary President]

[Dividends are apportioned each year.]

**POLICY INDEX**

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**SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE PPO (without Co-payment)**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Calendar Year Cash Deductible**

| | |
|---|---|
| Per Covered Person | [$250, $500 or $1,000] |
| Per Covered Family | [$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons |

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

**Hospital Confinement Co-Payment**

| | |
|---|---|
| —per day | $200 |
| —maximum Co-Payment per Period of Confinement | $1,000 |
| —maximum Co-Payment per Covered Person per Calendar Year | $2,000 |

**Emergency Room Co-Payment,** (waived if admitted within 24 hours)

| | |
|---|---|
| • if treatment, services or supplies are given by a Network Provider | None |
| • if treatment, services or supplies are given by a Non-Network Provider | $50 |

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

| | |
|---|---|
| • if treatment, services or supplies are given by a Network Provider | 20% |

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- if treatment, services or supplies are given by a Non-Network Provider 40%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

**Exception:** Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

**Coinsured Charge Limit:** $10,000

**SCHEDULE OF INSURANCE AND PREMIUM RATES** **EXAMPLE PPO (with Co-payment)**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Co-Payment**—If treatment, services or supplies are given by a Network Provider:

- Physician Visits $10
- Emergency Room (waived if admitted within 24 hours) $50
- Hospital Confinement $100 per day, up to $500 per confinement, $1,000 per Calendar Year

**Calendar Year Cash Deductible**—If treatment services or supplies are given by a Non-Network Provider

Per Covered Person [$250, $500 or $1,000]

Per Covered Family [$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

**Emergency Room Co-Payment,** (waived if admitted within 24 hours) (Non-Network Provider) $50

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

- if treatment, services or supplies are given by a Network Provider None
- if treatment, services or supplies are given by a Non-Network Provider 30%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

**Exception:** Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

**Coinsured Charge Limit:** $10,000

**SCHEDULE OF INSURANCE AND PREMIUM RATES** **EXAMPLE POS**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Co-Payment**—If treatment, services or supplies are given or referred by a PCP:

- Physician Visits $10
- Emergency Room (waived if admitted within 24 hours) $50
- Hospital Confinement $100 per day, up to $500 per confinement, $1,000 per Calendar Year

**Calendar Year Cash Deductible**—If treatment services or supplies are given by a Non-referred Provider

Per Covered Person [$250, $500 or $1,000]

Per Covered Family [$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

**Emergency Room Co-Payment,** (waived if admitted within 24 hours) (Out-Network Provider) $50

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

- if treatment, services or supplies are given by the PCP None, **except as stated below**
- if treatment, services or supplies are given or referred by a non referred Provider 20%, **except as stated below**

**Exception:** for Mental and Nervous and Substance Abuse charges

- if treatment, services or supplies are given or referred by the PCP 5%
- if treatment, services or supplies are given by a non-referred Provider 25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

**Exception:** Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

**Coinsured Charge Limit:** $10,000

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**PREMIUM RATES**

[The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

| Coverage | Premium Rate |
|---|---|
| Health Benefits | |
| —per Employee | $9999.99 |
| —per Employee and spouse | $9999.99 |
| —per Employee and children | $9999.99 |
| —per Employee, spouse and children | $9999.99] |

[Carrier] has the right to change any premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

**GENERAL PROVISIONS**

**THE POLICY**

The entire Policy consists of:

[a. the forms shown in the Policy Index as of the Effective Date;

b.] the Policyholder's application, a copy of which is attached to this Policy;

[c.] any riders, [endorsements] or amendments to this Policy and

[d. ]the individual applications, if any, of the persons covered.

**STATEMENTS**

No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:

a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or

b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person or the Covered Person's beneficiary.

All statements will be deemed representations and not warranties.

**INCONTESTABILITY OF THIS POLICY**

There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for 2 years.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

If this Policy replaces the policy of another insurer, [Carrier] may rescind this Policy based on misrepresentations made in the Policyholder's or a Covered Person's signed application for up to two years from this Policy's Effective Date.

**AMENDMENT**

This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]. [Carrier] may also make amendments to this Policy, as provided in b. and c. below. [Carrier] will give the Policyholder 30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of this Policy; or to extend the time in which a premium may be paid; or to make or change a Policy; or to bind [Carrier] by a promise or representation or by information given or received.

No change in this Policy is valid unless the change is shown in one of the following ways:

[a. It is shown in an endorsement on it signed by an officer of [Carrier].]

[b.] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the **Conformity With Law** section, it is shown in an amendment to it that is signed by an officer of [Carrier].

[c.] In the case of a change required by [Carrier], it is shown in an amendment to it that:

- is signed by an officer of [Carrier]; and
- is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.

[d. ]In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

**AFFILIATED COMPANIES**

If the Policyholder asks [Carrier] in writing to include an Affiliated Company under this Policy, and [Carrier] gives written approval for the inclusion, [Carrier] will treat Employees of that company like the Policyholder's Employees. [Carrier's] written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify [Carrier] in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

**PREMIUM AMOUNTS**

The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Policyholder and [Carrier].

The following will apply if one or more premiums paid include premium charges for an Employee whose coverage has ended before the due date of that premium. [Carrier] will not have to refund more than [the amount of a. minus b.:

a. The amounts of the premium charges for such Employee that were included in the premiums paid for the two months period immediately before the date [Carrier] receives written notice from the Policyholder that the Employee's coverage has ended.

b. The amount of any claims paid to an Employee for the Employee's claims or to a member of the Employee's family unit after that person's coverage has ended.]

**PAYMENT OF PREMIUMS—GRACE PERIOD**

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the first time this Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.

**PREMIUM RATE CHANGES**

The premium rates in effect on the Effective Date as shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a. Any premium due date.

b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.

c. Any date that the extent or nature of the risk under this Policy is changed:

- by amendment or this Policy; or
- by reason of any provision of law or any government program or regulation; or
- if this Policy supplements or coordinates with benefits provided by an other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.

d. At the discovery of a clerical error or misstatement as described below.

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e. As of the date the nature of the Policyholder's business changes.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

**PARTICIPATION REQUIREMENTS**

If this Policy provides coverage on a Non-contributory basis (the Policyholder pays the entire premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Non-contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

If this Policy provides coverage on a Contributory basis (the Employee pays part of the premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

**CLERICAL ERROR—MISSTATEMENTS**

Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will invalidate coverage otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], or the amount of coverage, subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy, and in what amounts.

**TERMINATION OF THE POLICY—RENEWAL PRIVILEGE**

[Carrier] has the right to cancel this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reasons:

a. During or at End of Grace Period—Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Policyholder may write to [Carrier], in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Policy will end on the date requested.
b. the Policyholder moves its principal place of business outside the State of New Jersey;
c. subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;
d. with respect to Contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:
    1. the Employee is covered as a Dependent under a spouse's coverage; or
    2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.); or

e. with respect to Non-contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:
    1. the Employee is covered as a Dependent under a spouse's coverage; or
    2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Policyholder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

This Policy is issued for a term of one (1) year from the Effective Date shown in the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section.

However, [Carrier] has the right to non-renew this Policy on any Policy Anniversary if the Policyholder is no longer a Small Employer.

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the actions described above as of the Employer's Policy Anniversary.

[Also, if the nature of the Employer's business changes, the Employer must notify [Carrier] within 30 days. [Carrier] has the right to change the rates [Carrier] charges for this Policy if this happens. If the Employer fails to notify [Carrier] within 30 days, [Carrier] has the right to adjust premium rates retroactively to the date the nature of the Employer's business changed.] **[Note: This section will sunset January 1, 1997]**

**[DIVIDENDS**

[Carrier] will determine the share, if any, of its divisible surplus allocable to this Policy as of each Policy Anniversary, if this Policy stays in force by the payment of all premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under this Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

**EMPLOYEE'S CERTIFICATE**

[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:

(1) to whom [Carrier] pays benefits,
(2) any protection and rights when the coverage ends and
(3) claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

**OFFSET**

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

**CONTINUING RIGHTS**

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under this Policy.

**ASSIGNMENT BY POLICYHOLDER**

Assignment or transfer of the interest of the Policyholder under this Policy will not bind [Carrier] without [Carrier's] written consent thereto.

**CONFORMITY WITH LAW**

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

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**LIMITATION OF ACTIONS**

No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

**WORKERS' COMPENSATION**

The health benefits provided under this Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

**NOTICES AND OTHER INFORMATION**

Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid, addressed as follows:

If to [Carrier]: To the last address on record with the Policyholder.

If to a Covered Person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to [Carrier].

If to the Policyholder: To the last address of the Policyholder on record with [Carrier].

**RECORDS—INFORMATION TO BE FURNISHED**

[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by [Carrier], the Policyholder will send the data required by [Carrier] to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder and of the Employer which bear on this Policy must be open to [Carrier] for its inspection at any reasonable time.

[Carrier] will not have to perform any duty that depends on such data before it is received in a form that satisfies [Carrier]. The Policyholder may correct wrong data given to [Carrier], if [Carrier] has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish [Carrier] the Employee and Dependents eligibility requirements of this Policy that apply on the Effective Date. Subject to [Carrier's] approval, those requirements will apply to the Employee and Dependent coverage under this Policy. The Policyholder will notify [Carrier] of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee or Dependent coverage under this Policy unless approved in advance by [Carrier].

The Policyholder will notify [Carrier] of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of [Carrier] to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. [If the Policyholder fails to notify [Carrier] as provided above, [Carrier] will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person's coverage has ended.]

**CLAIMS PROVISIONS**

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

**[NOTICE OF LOSS**

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

**PROOF OF LOSS**

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

**PAYMENT OF CLAIMS**

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [Carrier] may honor such direction at [Carrier's] option. The Employee may not assign his or her right to take legal action under this Policy to such provider.

**PHYSICAL EXAMS**

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

**LIMITATIONS OF ACTIONS**

An Employee cannot bring a legal action against this Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against this Policy after three years from the date he or she files proof of loss.

**[PLANHOLDERS**

The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

**How an Employer becomes a Planholder**

An Employer must submit a signed application in which he:

- agrees to participate in the trust, and
- applies for the insurance provided by this Policy for his Employees.

**When an Employer becomes a Planholder**

The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

**When an Employer ceases to be a Planholder**

The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

**Data needed**

The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[**Note:** This text, which may be modified by each carrier in order to accommodate various trust agreements, is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

**DEFINITIONS**

**The words shown below have special meanings when used in this Policy. Please read these definitions carefully. [Throughout this Policy, these defined terms appear with their initial letter capitalized.]**

**Actively at Work** or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

**Alcohol Abuse** means abuse of or addiction to alcohol.

**Ambulance** means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

**Ambulatory Surgical Center** means a Facility mainly engaged in performing Outpatient Surgery. It must:

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a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

**Anniversary Date** means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

**Affiliated Company** means a corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets.

**Birthing Center** means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:
a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:
a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

**Board** means the Board of Directors of the New Jersey Small Employer Health Program.

**Calendar Year** means each successive 12 month period which starts on January 1 and ends on December 31.

**Cash Deductible** means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. See the **The Cash Deductible** section of this Policy for details.

**Co-Insurance** means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

**Co-Payment** means a specified dollar amount a Covered Person must pay for specified Covered Charges.

**Covered Charges** are Reasonable and Customary charges for the types of services and supplies described in the **Coverage Charges** and **Covered Charges With Special Limitations** section of this Policy. The services and supplies must be:
a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while or he or she is insured by this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

**Covered Person** means an Eligible Employee or a Dependent who is insured under this Policy.

**Current Procedural Terminology** (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

**Custodial Care** means any service or supply, including room and board, which:
a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

**Dependent** means an Employee's:
a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. his or her unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:
a. on active duty in any armed forces of any country; or
b. eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

An Employee's "unmarried Dependent child" includes:
a. his or her legally adopted children.
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

**Diagnostic Services** means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

**Discretion** means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

**Durable Medical Equipment** is equipment which:
a. is designed and able to withstand repeated use;
b. is primarily and customarily used to serve a medical purpose;
c. is generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. is suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

**Effective Date** means the date on which coverage begins under this Policy for the Employer, or the date coverage begins under this Policy for an Employee or Dependent, as the context in which the term is used suggests.

**Employee** means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility.

**Employer** means [ABC Company].

**Experimental or Investigational** means [Carrier] determines a service or supply is:
a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

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Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

**Extended Care Center** means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

**Facility** means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

**Full-Time** means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

**Generic Drug** means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

**Government Hospital** means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

**Home Health Agency** means a Provider which mainly provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

**Hospice** means a Facility which mainly provides palliative and supportive care for terminally ill people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or
b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

**Hospital** means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission or
b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

**Illness** means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

**Initial Dependent** means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

**Injury** means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

**Inpatient** means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility.

**Joint Commission** means the Joint Commission on the Accreditation of Health Care Facilities.

**Late Enrollee** means an eligible Employee or Dependent who requests enrollment under this Policy more than 30 days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** sections of this Policy.

**Medical Emergency** means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

**Medically Necessary and Appropriate** means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c. in accordance with accepted medical standards in the community at the time;
d. not for the convenience of a Covered Person;
e. the most appropriate level of medical care the Covered Person needs;
f. accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
g. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

**Medicaid** means the health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

**Medicare** means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the Social Security Act, as amended from time to time.

**Mental Health Centers** mainly provide treatment for people with mental health problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare.

**Mental and Nervous Condition** means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

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**Newly Acquired Dependent** means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

**Non-Covered Charges** are charges which do not meet this Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

**Nurse** means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

**Outpatient** means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

**Per Lifetime** means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption.

**Period of Confinement** means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

**Plan** means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan".]

**Planholder** means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder".]

**Policy** means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

**Policyholder** means the Employer who purchased this Policy.

**Practitioner** means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

**Pre-Approval or Pre-Approved** means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

**Pre-Existing Condition** means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

**Prescription Drugs** are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

**Preventive Care** means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

**Provider** means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

**Reasonable and Customary** means an amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board. When [Carrier] decides what is reasonable, it looks at the Covered Person's condition and how severe it is. [Carrier] also looks at special circumstances. The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the range of usual fees

charged by most Providers of similar training and experience for the same service within the same geographic area.

**Outpatient** means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

**Per Lifetime** means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption.

**Plan** means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan".]

**Planholder** means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder".]

**Policy** means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

**Policyholder** means the Employer who purchased this Policy.

**Practitioner** means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

**Pre-Approval or Pre-Approved** means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

**Pre-Existing Condition** means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

**Prescription Drugs** are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

**Preventive Care** means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

**Provider** means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

**Reasonable and Customary** means an amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board. When [Carrier] decides what is reasonable, it looks at the Covered Person's condition and how severe it is. [Carrier] also looks at special circumstances. The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the range of usual fees charged by most Providers of similar training and experience for the same service within the same geographic area.

**Rehabilitation Center** means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commissioner or the Commission on Accreditation for Rehabilitation Facilities; or
b. approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

**Routine Foot Care** means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic

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complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

**Routine Nursing Care** means the nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

**Schedule** means the **Schedule of Insurance and Premium Rates** contained in this Policy.

**Skilled Nursing Care** means services which are more intensive than Custodial Care, are provided by a registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

**Skilled Nursing Center** (see Extended Care Center.)

**Small Employer** means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

**Special Care Unit** means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a. intensive care units;
b. cardiac care units;
c. neonatal care units; and
d. burn units.

**Substance Abuse** means abuse of or addiction to drugs.

**Substance Abuse Centers** are Facilities that mainly provide treatment for people with substance abuse problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare.

**Surgery** means:

a. the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;
b. the correction of fractures and dislocations;
c. Reasonable and Customary pre-operative and post-operative care; or
d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

**Therapeutic Manipulation** means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting fro the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydro therapy or other treatment of similar nature.

**Total Disability or Totally Disabled** means, except as otherwise specified in this Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[**We, Us, Our** and **[Carrier]** mean [Carrier].]

[**You, Your and Yours** mean the Employer.]

## EMPLOYEE COVERAGE

### Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

### Conditions of Eligibility

### Full-Time Requirement

[Carrier] will not insure an Employee unless the Employee is an Actively at Work Full-Time Employee.

### Enrollment Requirement

If an employee must pay part of the cost of Employee Coverage, [Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments. If the Employee does this:

a. more than 30 days after the Employee first becomes eligible; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under this Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee must enroll under this Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

### [The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete 3 months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete 3 months of continuous Full-Time service with the Employer.]

### Multiple Employment

If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one firm Employs the Employee. And such an Employee will not have multiple coverage under this Policy. But, if this Policy uses the amount of an Employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

### When Employee Coverage Starts

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility, which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The scheduled Effective Date of an Employee's coverage is as follows:

a. if an Employee must pay part of the cost of Employee coverage, then he or she must elect to enroll and agree to make the required payments within 30 days of his or her eligibility date. If he or she does this within 30 days of his or her eligibility date, his or her coverage is scheduled to start on his or her eligibility date.
b. On non-contributory plans, subject of all the terms of this plan, an Employee's coverage starts on his or her eligibility date.

### When Employee Coverage Ends

An Employee's insurance under this Policy will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.

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b. [the date] an Employee stops being an eligible Employee under this Policy.
c. the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d. the last day of the period for which required payments are made for the Employee.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Policy's benefits provisions explain these situations. Read this Policy's provisions carefully.

**DEPENDENT COVERAGE**

**Eligible Dependents for Dependent Health Benefits**

An Employee's eligible Dependents are:
a. the Employee's legal spouse;
b. the Employee's unmarried Dependent children who are under age 19; and
c. the Employee's unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:
a. on active duty in any armed forces of any country; or
b. eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this Policy.

An Employee's "unmarried Dependent child" includes:
a. his or her legally adopted children,
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

**Incapacitated Children**

An Employee may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past this Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:
a. the child's condition started before he or she reached this Policy's age limit;
b. the child became insured by this Policy before the child reached the age limit, and stayed continuously insured until reaching such limit; and
c. the child depends on the Employee for most of their support and maintenance.

But, for the child to stay eligible, the Employee must send [Carrier] written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

**Enrollment Requirement**

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:
a. enrolls a Dependent and agrees to make the required payments after the end of the enrollment period;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Policy because they were covered under another group plan, and the Employee now elects to enroll them in this Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur.

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Policy, to be a Late Enrollee, if:
a. the Employee is under legal obligation to provide coverage due to a court order; and
b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date he or she becomes eligible.

**When Dependent Coverage Starts**

In order for an Employee's dependent coverage to begin the Employee must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of this Policy, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this on or before the Employee's eligibility date, the Dependent's Coverage is scheduled to start on the later of:
a. the Employee's eligibility date, or
b. the date the Employee becomes insured for Employee coverage.

If the Employee does this within or after the enrollment period, the coverage is scheduled to start on the later of:
a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes insured for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify [Carrier] of a Newly Acquired Dependent within the enrollment period. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:
a. the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b. the date the newly Acquired Dependent is first eligible.

**Exception:** If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

**Newborn Children**

[Carrier] will cover an Employee's newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:
a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

**When Dependent Coverage Ends:**

A Dependent's insurance under this Policy will end on the first of the following dates:

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a. [the date] Employee coverage ends;
b. the date the Employee stops being a member of a class of Employees eligible for such coverage;
c. the date this Policy ends;
d. the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class.
e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.
f. the date the Dependent stops being an eligible Dependent. This happens at 12:01 a.m. on the date:
   - the child attains the Policy's age limit;
   - the Dependent child marries;
   - a step-child is no longer dependent on the Employee for support and maintenance;
   - a spouse's marriage ends in legal divorce or annulment.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.

**PREFERRED PROVIDER ORGANIZATION PROVISIONS**

**The Employer XYZ Health Care Network, and the [Carrier]**

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of this Policy. The Employee should read his or her certificate carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If an Employee has any questions after reading his or her Certificate, he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

**POINT OF SERVICE PROVISIONS**

**Definitions**

a. ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of Practitioners who are members of the [XYZ] Provider Organization to the Covered Person.
b. ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c. ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.
d. ***Out-Network Benefits*** means the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e. ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

**Provider Organization (PO)**

The Provider Organization for this Policy is the [XYZ] Provider Organization. This Policy requires that the Covered Person uses the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

**The Primary Care Physician (PCP)**

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person **must** obtain an authorized referral from his or her PCP **before** he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she will not be eligible for Network Benefits.

[Carrier] pays Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, Out-Network Benefits will be provided.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

**Out-Network Services**

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, Out-Network Benefits will be paid.

**Emergency Services**

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the Service Area of the EPO.

**Utilization Review**

This Policy has utilization features. See the **Utilization Review Features** section of this Policy.

**Benefits**

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of this Policy.

[**Note:** Used only if coverage is offered as POS.]

**SCHEDULE OF INSURANCE AND PREMIUM RATES** **EXAMPLE POS**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

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**CLASS**

[All eligible employees]

**EMPLOYEE AND DEPENDENT HEALTH BENEFITS**

**Co-Payment**—If treatment, services or supplies are given or referred by a PCP:

| | |
|---|---|
| • Physician Visits | $10 |
| • Emergency Room (waived if admitted within 24 hours) | $50 |
| • Hospital Confinement | $100 per day, up to $500 per confinement, $1,000 per Calendar Year |

**Calendar Year Cash Deductible**—If treatment services or supplies are given by a Non-referred Provider

| | |
|---|---|
| Per Covered Person | [$250, $500 or $1,000] |
| Per Covered Family | [$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons |

**Medicare Alternate Deductible**

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

| | |
|---|---|
| **Emergency Room Co-Payment,** (waived if admitted within 24 hours) (Out-Network Provider) | $50 |

**Co-Insurance**

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

| | |
|---|---|
| • if treatment, services or supplies are given by the PCP | None, **except as stated below** |
| • if treatment, services or supplies are given or referred by a non-referred Provider | 20%, **except as stated below** |

**Exception:** for Mental and Nervous and Substance Abuse charges

| | |
|---|---|
| • if treatment, services or supplies are given or referred by the PCP | 5% |
| • if treatment, services or supplies are given by a non-referred Provider | 25% |

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

**Exception:** Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

| | |
|---|---|
| **Coinsured Charge Limit:** | $10,000 |

**HEALTH BENEFITS INSURANCE**

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

**Note: [Carrier] payments will be reduced or limited if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.**

**BENEFIT PROVISION**

**The Cash Deductible**

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

**Family Deductible Limit**

This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.

**Co-Insurance Cap**

This Policy limits Co-Insurance amounts each Calendar Year **except** as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;
b. Cash Deductibles;
c. Co-Insurance paid by a Covered Person for the treatment of Mental and Nervous Conditions and Substance Abuse; and
d. Co-Payments.

There are Co-Insurance Caps for:

a. each Covered Person; and
b. each Covered Family.

The Co-Insurance Caps are shown in the Schedule.

Each Covered Person's Co-Insurance amounts are used to meet his or her own Co-Insurance Cap, and are combined with Co-Insurance amounts from other covered family members to meet the covered family's Co-Insurance Cap. But all amounts used to meet the cap must actually be paid by a Covered Person out of his or her own pocket.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.

Once two Covered Persons in a family meet their individual Co-Insurance amounts, [Carrier] will waive the family's Co-Insurance for the rest of that Calendar Year.

**Exception:** Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the Co-Insurance Cap.

**Payment Limits**

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

**Benefits From Other Plans**

The benefits [Carrier] will pay may be affected by a Covered Person being covered by two or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **How This Policy Interacts With Medicare** section for an explanation of how this works.

**If This Plan Replaces Another Plan**

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which this Policy starts;
b. this Policy would have paid benefits for the charges, if this Policy had been in effect;
c. The Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d. this Policy starts right after the old plan ends.

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**Extended Health Benefits**

If this Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under this Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of this Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or
b. one year from the date the person's insurance under this Policy ends; or
c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

**COVERED CHARGES**

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

**Hospital Charges**

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's **Emergency Room Co-Payment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

**Hospital Co-Payment Requirement**

Each time a Covered Person is confined in a Hospital, he or she must pay a $200 Co-Payment for each day of confinement, up to a maximum of $1,000 per confinement, subject to a maximum $2,000 Co-Payment per Calendar Year.

**Emergency Room Co-Payment Requirement**

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50] Co-Payment, if he or she is not admitted within 24 hours.

**Pre-Admission Testing Charges**

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

**COVERED CHARGES**

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

**Hospital Charges**

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's **Emergency Room Co-Payment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

**Emergency Room Co-Payment Requirement**

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

**Pre-Admission Testing Charges**

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

**Extended Care and Rehabilitation Charges**

Subject to [Carrier's] Pre-Approval [Carrier] covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 2 days of a Hospital stay; and
b. be due to the same or a related condition that necessitated the Hospital stay.

And [Carrier] will only cover the first 120 days of confinement in each Calendar year. Charges for any additional days are a Non-Covered Charge.

But [Carrier] limits what [Carrier] will pay for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

**Extended Care and Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

**Home Health Care Charges**

Subject to [Carrier's] Pre-Approval, when home health care can take the place of inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Policy and to the following conditions:

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a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
b. The services and supplies must be:
- ordered by the Covered Person's Practitioner;
- included in the home health care plan; and
- furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once very 60 days.
d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
e. [Carrier] does not pay for:
- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

**Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

**Practitioner's Charges for Non-Surgical Care and Treatment**

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But [Carrier] limits what [Carrier] will pay for the treatment of mental and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

**Practitioner's Charges for Surgery**

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

**Second Opinion Charges**

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b. are not business associates of the Practitioner who recommended the Surgery; and
c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

**Dialysis Center Charges**

[Carrier] covers charges made by a dialysis center for covered dialysis services.

**Ambulatory Surgical Center Charges**

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

**Hospice Care Charges**

Subject to [Carrier] Pre-Approval, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill Covered person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness.

"Terminally ill" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, [Carrier] covers any services and supplies including Prescription drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

**Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

**Alcohol Abuse**

[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Treatment may be furnished by:

a. a Hospital;
b. a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c. a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

**Pregnancy**

This Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

**Birthing Center Charges**

[Carrier] covers Birthing Center charges made by a practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

**Benefits for a Covered Newborn Child**

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

Subject to all of the terms of this Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

**Anesthetics and Other Services and Supplies**

[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But [Carrier] does not pay for replacements or repairs.

**Blood**

[Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

**Ambulance Charges**

[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:

a. a local Hospital if needed care and treatment can be provided by a local Hospital;
b. the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c. transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not

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pay for other travel or communication expenses of patients. Practitioners, Nurses or family members.

**Durable Medical Equipment**

Subject to [Carrier's] Pre-Approval, [Carrier] covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At [Carrier's] option, and with [Carrier's] Pre-Approval, [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:

a. any purchases without [Carrier's] advance written approval;
b. replacements or repairs; or
c. the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of Durable Medical Equipment.

**Charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

**Treatment of Wilm's Tumor**

[Carrier] pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. [Carrier] treats such charges the same way [Carrier] treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. [Carrier] pays benefits for this treatment even if it is deemed Experimental or Investigational. What [Carrier] pays is based on all of the terms of this Policy.

**X-Rays and Laboratory Tests**

[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's **Preventive Care** section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

**Prescription Drugs**

[Carrier] covers drugs which require a Practitioner's prescription. But [Carrier] only covers drugs which are approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration, in no event will [Carrier] pay for drugs labeled: "Caution—Limited by Federal Law to Investigational Use". And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

**COVERED CHARGES WITH SPECIAL LIMITATIONS**

**Dental Care and Treatment**

[Carrier] covers:

a. the diagnosis and treatment of oral tumors and cysts; and
b. the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:

a. the Injury occurs while the Covered Person is insured under any health benefit plan;
b. the Injury was not caused, directly or indirectly by biting or chewing; and
c. all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event does [Carrier] cover orthodontic treatment.

**Treatment for Temporomandibular Joint Disorder (TMJ)**

[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

**Prosthetic Devices**

[Carrier] limits what [Carrier] pays for prosthetic devices. Subject to [Carrier] Pre-Approval, [Carrier] covers only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Covered Person's body, or be needed due to a functional birth defect in a covered Dependent child. [Carrier] does not pay for replacements, unless they are Medically Necessary and Appropriate. [Carrier] does not pay for repairs, wigs, or dental prosthetics or devices.

**Charges for Prosthetic Devices which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

**Mammogram Charges**

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

[Carrier] will cover charges for:

a. one baseline mammogram for a female Covered Person, ages 35-39
b. one mammogram, every 2 years, for a female Covered Person, ages 40-49, or more frequently, if recommended by a Practitioner, and
c. one mammogram, every year, for a female Covered Person ages 50 and older.

**The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any 30 day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE and DEPENDENT COVERAGE sections to determine if a Covered Person is a Late Enrollee.**

**Pre-Existing Conditions**

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by this Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

**Continuity of Coverage**

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in this Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

**Private Duty Nursing Care**

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

**Therapy Services**

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below.

a. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

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b. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment*—the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

[Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.
g. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

h. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.
i. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.

Coverages for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

j. *Infusion Therapy*—subject to [Carrier] Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. **Charges in connection with Infusion Therapy which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

**Preventive Care**

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to:

a. $500 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and
b. $300 per Covered Person for all other Covered Persons.

These changes are not subject to the Cash Deductibles or Co-Insurance.

**Therapeutic Manipulation**

[Carrier] limits what [Carrier] covers for spinal manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

**Mental and Nervous Conditions and Substance Abuse**

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. [Carrier] includes an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker.

The Covered Person must pay the Co-Insurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits what [Carrier] pays each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. [Carrier] limits what [Carrier] pays Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

[Carrier] does not pay for Custodial Care, education, or training.

**Transplant Benefits**

[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:

a. Cornea
b. Kidney
c. Lung
d. Liver
e. Heart
f. Pancreas
g. Allogeneic Bone Marrow
h. Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
   - Leukemia
   - Lymphoma
   - Neuroblastoma
   - Aplastic Anemia
   - Genetic Disorders
     —SCID
     —WISCOT Alldrich

**IMPORTANT NOTICE**

This Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or
b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.

This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.

This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.

What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

**UTILIZATION REVIEW FEATURES**

**Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.**

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;
b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

**Definitions**

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

**Grievance Procedure**

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical

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review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals].

**REQUIRED HOSPITAL STAY REVIEW**

**Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.**

**Notice of Hospital Admission Required**

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

**Pre-Hospital Review**

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission
b. the anticipated length of stay and
c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

**Emergency Admission**

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;
b. the Covered Person group plan number;
c. the reason for the admission;
d. the name and location of the Hospital;
e. when the admission occurred; and
f. the name of the Covered Person's Practitioner.

**Continued Stay Review**

The Covered Person or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

**Penalties for Non-Compliance**

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges, **by 50%** if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges **by 50%**, if:

a. [ABC] is not notified of the admission at the times and in the manner described above; or
b. the Covered Person does not request a continued stay review.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends **by 50%** as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.

**REQUIRED PRE-SURGICAL REVIEW**

**Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.**

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

**Required Second Surgical Opinion**

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from a Practitioner on the list, or from a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;

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b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

**Pre-Hospital Review**

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

**Penalties for Non-Compliance**

As a penalty for non-compliance, [Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%** if:

a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done.
d. [ABC] does not confirm the need for Surgery.

But there is no penalty when the additional opinions do not confirm the need for the Surgery, and the Surgery is done anyway.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.

**ALTERNATE TREATMENT FEATURES**

**Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].**

**Definitions**

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

**Alternate Treatment Plan**

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - [DEF]
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and per lifetime maximums.

**Exclusion**

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.

**CENTERS OF EXCELLENCE FEATURES**

**Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.**

**Definitions**

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

**Covered Charges**

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]

**EXCLUSIONS**

**Payment will not be made for any charges incurred for or in connection with:**

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

***Blood or blood plasma*** which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

***Completion of claim forms.***

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in this Policy, unless it is required as a result of an Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

***Dental care*** or treatment, including appliances, except as otherwise stated in this Policy.

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

***Experimental or Investigational*** treatments, procedures, hospitalizations, drugs, biological products or medical devices.

***Extraction of teeth,*** except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;

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b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance ***fertility*** using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to ***Hearing aids, hearing examinations*** or fitting of hearing aids.

Services or supplies related to ***Herbal medicine.***

Care or treatment by means of ***high dose chemotherapy,*** except as otherwise stated in this Policy.

Services or supplies related to ***Hypnotism.***

Services or supplies because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit a felony.

***Illness*** or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

***Local anesthesia*** charges billed separately if such charges are included in the fee for the Surgery.

***Membership costs*** for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate.

***Non-prescription drugs*** or supplies, except insulin needles and syringes.

Services provided by a licensed ***pastoral counselor*** in the course of his or her normal duties as a religious.

***Personal convenience*** or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care,*** except as provided under the Home Health Care section of this Policy.

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

Services or supplies related to ***rest or convalescent cures.***

***Room and board charges*** for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

***Self-administered services*** such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker,*** except as otherwise stated in this Policy.

***Services or supplies:***

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Covered Person would not have been charged if he or she did not have health care coverage;
d. provided by or in a government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury.

***Smoking cessation*** aids of all kinds and the services of stop-smoking providers.

***Stand-by services required by a Provider.***

***Sterilization reversal***—services and supplies rendered for reversal of sterilization.

***Surgery,*** sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

***Telephone consultations.***

***Transplants,*** except as otherwise listed in this Policy.

***Transportation;*** travel.

***Vision therapy.***

***Vitamins and dietary supplements.***

Services or supplies received as a result of a ***war,*** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

***Weight reduction or control,*** unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

***Wigs, toupees, hair transplants, hair weaving or any drug*** used in connection with baldness.

## CONTINUATION RIGHTS

### COORDINATION AMONG CONTINUING RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this Policy's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under both this Policy's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

### AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

**The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:**

**a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, and therefore;**
**b. the section applies to the Employee.**

### COBRA CONTINUATION RIGHTS

#### Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Policy during a continuation provided by this section is not qualified continuee.

#### If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

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a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:
a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

**Extra Continuation for Disabled Qualified Continuees**

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

**If An Employee Dies While Insured**

If an Employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

**If An Employee's Marriage Ends**

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

**If A Dependent Loses Eligibility**

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

**Concurrent Continuations**

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

**The Qualified Continuee's Responsibilities**

A person eligible for continuation under this section must notify the Employer, in writing, of:
a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

**The Employer's Responsibilities**

The Employer must notify the qualified continuee, in writing, of:
a. his right to continue this Policy's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:
a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hour; or
b. the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

**The Employer's Liability**

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:
a. the Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

**Election of Continuation**

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

**Grace in Payment of Premiums**

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

**When Continuation Ends**

A qualified continuee's continued group health benefits end on the first of the following:
a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act.
c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

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e. the date this Policy ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this policy's **Conversion Rights for Divorced Spouses** section for details.

**NEW JERSEY GROUP CONTINUATION RIGHTS**

**Important Notice**

This section applies only to group health benefits. This section does not apply to any other coverages provided by this Policy.

**If An Employee's Group Benefits End**

If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

**What The Employee Must Do**

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Policy on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

**The Continued Coverage**

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Policy on a regular basis. Any modifications made under this Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for an Employee to continue.

**When Continuation Ends**

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Covered Person becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Covered Person becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person;
e. with respect to a Covered Person who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefits plan for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Policy.

**A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS**

**If An Employee is Totally Disabled**

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

**How And When To Continue Coverage**

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

**When This Continuation Ends**

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying.
b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

**AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE**

**Important Notice**

**This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:**

- **the Employer must allow for a leave of absence under Federal law and, therefore**
- **the section applies to the Employee.**

**If An Employee's Group Health Coverage Ends**

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

**When Continuation Ends**

Insurance may continue until the earliest of:

a. the date the Employee returns to Full-time work
b. the end of a total period of 12 weeks in any 12 month period, or
c. the date on which the Employee's coverage would have ended had the Employee not been on leave.

**A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS**

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

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a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Policy.

## CONVERSION RIGHTS FOR DIVORCED SPOUSES

### IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health coverage ends. See **exceptions** below.

**Exceptions**

No former spouse may use this conversion right:
- unless he or she has been insured under this Policy for at least 3 months;
- if he or she is eligible for Medicare; or
- if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

### HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

### THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health coverage under this Policy ends.

After group health coverage under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.

## EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the medical care benefits provided by this Policy. If the Employer does, the following provisions apply.

### IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

**Date Medical Care Insurance Ends**

Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

**Benefits After Medical Care Insurance Ends**

When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

**Exception:**

**IF:** on the date membership takes effect, the HMO does not provide benefits due to:
- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

**AND** the HMO provides benefits for total disability when membership ends

**THEN** medical care benefits will be paid until the first of the following occurs:
- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

### IF AN HMO MEMBER ELECTS MEDICAL CARE INSURANCE PROVIDED BY THIS POLICY

**Date Transfer To Such Insurance Takes Effect**

Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

**request made during an open enrollment period**

[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

**request made because:**
- **an HMO ends its operations**
- **Employee moves outside the HMO service area**

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

**request made because an HMO becomes insolvent**

If an Employee requests insurance because membership ends for this reason, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

**request made at any other time**

An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

**Other Provisions Affected By A Transfer**

If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:
- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

**Charges not covered**

Charges incurred before a person becomes insured will not be considered Non-Covered Charges.

**Maximum benefit**

The total amount of benefits to be paid for each person will be the maximum benefit specified in this policy, regardless of any interruption in such person's insurance under this Policy.

**Right to change premium rates**

[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

## COORDINATION OF BENEFITS

**Important Notice**

This provision applies to all health expense benefits under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

**Purpose Of This Provision**

An Employee may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier]

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pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

**DEFINITIONS**

"Plan" means any of the following that provide health expenses or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. group or group-type hospital indemnity benefits which exceed $150.00 per day.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits of $150.00 per day or less; and
d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

**How This Provision Works**

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

**[Carrier's] Right To Certain Information**

In order to coordinate benefits, [Carrier] needs certain information. An Employee must supply [Carrier] with as much of that information as he or she can. But if he or she cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or get information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

**Small Claims Waiver**

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

**BENEFITS FOR AUTOMOBILE RELATED INJURIES**

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related injury.

**Definitions**

"Automobile Related Injury" means bodily injury sustained by a Covered Person as a result of an accident.

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. this Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without applicaiton of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

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**Determination of primary or secondary coverage.**

This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for One Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

**Benefits this Policy will pay if it is primary to PIP or OSAIC.**

If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Policy will apply if:

- the Covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

**Benefits this Policy will pay if it is secondary to PIP or OSAIC.**

If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the benefits that would have been paid if this Policy had been primary.

**Medicare**

If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

## HOW THIS POLICY INTERACTS WITH MEDICARE

### IMPORTANT NOTICE

**The following section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:**

- **the Employer is subject to the How This Plan Interacts with Medicare section and therefore;**
- **the section applies to the Employee**

The following provisions explain how this plan's group health benefits interact with the benefits available under Medicare. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as shown below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the Social Security Act, as amended from time to time.
b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".

[d. "We" means Carrier]

## MEDICARE ELIGIBILITY BY REASON OF AGE

**Applicability**

This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible."

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

**When An Employee or Insured Spouse Becomes Eligible For Medicare**

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option A—The Medicare eligible may choose this Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Policy is Primary** section below, for details.

Option B—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

**When this Policy is primary**

When a Medicare eligible chooses this Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

**When Medicare is primary**

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

## MEDICARE ELIGIBILITY BY REASON OF DISABILITY

**Applicability**

This section applies to a Covered Person who is:

a. under age 65; and
b. eligible for Medicare by reason of End Stage Renal Disease.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or
b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

**When A Covered Person Becomes Eligible For Medicare**

When a Covered Person becomes eligible for Medicare by reason of disability, this Policy supplements the benefit provided by Medicare.

If the disabled Medicare incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, [Carrier] subtracts what Medicare pays from what [Carrier] normally pays.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

## MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

**Applicability**

This section applies to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

**When A Covered Person Becomes Eligible For Medicare Due to ESRD**

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are

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payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and
b. with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, [Carrier] supplements what Medicare pays. [Carrier] subtracts what Medicare pays from what [Carrier] normally pays. If a Covered Person is eligible for Medicare solely on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

**RIGHT TO RECOVERY—THIRD PARTY LIABILITY**

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

**STATEMENT OF ERISA RIGHTS**

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

**CLAIMS PROCEDURE**

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.
b. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.
c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:
   - the specific reason(s) the claim is denied;
   - specific references to the pertinent plan provision on which the denial is based;
   - a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
   - and explanation of the plan's claim review procedure.

A claimant must file a request review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing. [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

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EXHIBIT G

**HMO PLAN**
**[Carrier]**

**SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT**

**CONTRACT HOLDER:** [ABC Company]

**GROUP CONTRACT NUMBER**
[G-12345]

**GOVERNING JURISDICTION**
NEW JERSEY

**EFFECTIVE DATE OF CONTRACT**
[January 1, 1994]

**CONTRACT ANNIVERSARIES:** [January 1st of each year, beginning in 1995.]

**PREMIUM DUE DATES:** [Effective Date, and the first day of the month beginning with February, 1994.]

**AFFILIATED COMPANIES:** [DEF Company]

[Carrier], in consideration of the application for this Contract and of the payment of premiums as stated herein, agrees to arrange [or provide] services in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Contract.

The Effective Date is specified above.

This Contract takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in its General Provisions.

[Secretary President]

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**I. SCHEDULE OF PREMIUM RATES**

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:

Subscriber Only ..... $
Subscriber and Spouse ..... $
Subscriber and Child(ren) ..... $
Subscriber and Family ..... $
(including Subscriber, spouse and one or more eligible dependents)]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Contract entitled "Contract Holder General Provisions."

**II. SCHEDULE OF SERVICES & BENEFITS**

**BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER MEMBER, UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.**

**[COPAYMENTS:**

**HOSPITAL SERVICES:**

**INPATIENT**
$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.

**OUTPATIENT**
$15 Copayment/visit

**DOCTOR SERVICES:**

**INPATIENT**
None

**OUTPATIENT**
$15 Copayment/visit; no Copayment if any other Copayment applies.

**EMERGENCY ROOM**
$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as a result of the same or related illness or Injury for which the person visited the Emergency Room)

**OUTPATIENT SURGERY**
$15 Copayment/visit.

**HOME HEALTH CARE**
Unlimited days, if preapproved.

**HOSPICE CHARGES**
Unlimited days, if preapproved.

**MATERNITY (PRE-NATAL CARE)**
$25 Copayment for initial visit only.

**MENTAL NERVOUS CONDITIONS AND SUBSTANCE ABUSE:**

**OUTPATIENT**
$15 Copayment/visit; maximum 20 visits/Calendar Year.

**INPATIENT**
$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500/Calendar Year.
Maximum of 30 days inpatient care/Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.

**PODIATRIC**
$15 Copayment/visit (excludes Routine Foot Care).

**PRE-ADMISSION TESTING**
$15 Copayment/visit.

**PRESCRIPTION DRUG**
50% Coinsurance [May be substituted by Carrier with $15 Copayment.]

**PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES**
$15 Copayment/visit.

**PRIMARY CARE SERVICES**
$15 Copayment/visit.

**SECOND SURGICAL OPINION**
$15 Copayment/visit.

**SPECIALIST SERVICES**
$15 Copayment/visit.

**SKILLED NURSING CENTER**
Unlimited days, if preapproved.

**THERAPY SERVICES**
$15 Copayment/visit.

**X-RAY & LAB (OUTPATIENT)**
$15 Copayment/visit.

**NOTE: NO BENEFITS WILL BE PROVIDED IF A MEMBER FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.**

**REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.**

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**III. DEFINITIONS**

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help Members understand what services are provided.

[**ACTIVELY AT WORK or ACTIVE WORK.** Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.]

**ALCOHOL ABUSE.** Abuse of or addiction of alcohol.

**AMBULANCE.** A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

**ANNIVERSARY DATE.** The date which is one year from the Effective Date of this Contract and each succeeding yearly date thereafter.

**AFFILIATED COMPANY.** A corporation or other business entity affiliated with the Contract Holder through common ownership of stock or assets.

**BOARD.** The Board of Directors of the New Jersey Small Employer Health Program.

**CALENDAR YEAR.** Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

[**COINSURANCE.** The percentage of Covered Services or Supplies that must be paid by a Member. Coinsurance does not include Copayments.]

**CONTRACT.** This contract, including the application and any riders, amendments or endorsements, between the Employer and [Carrier].

**CONTRACT HOLDER.** Employer or organization which purchased this Contract.

**COPAYMENT.** A specified dollar amount which Member must pay for certain Covered Services or Supplies.

**COVERED SERVICES OR SUPPLIES.** The types of services and supplies described in the "Covered Services and Supplies" section of this Contract.

Read the entire Contract to find out what We limit or exclude.

**CUSTODIAL CARE.** Any service or supply, including room and board, which:

a. is furnished mainly to help Member meet Member's routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

**DEPENDENT.**

An Employee's:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. his or her unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school.

Under certain circumstances, an incapacitated child is also a Dependent. See the Eligibility section of this Contract.

An Employee's "unmarried Dependent child" includes his or her legally adopted child, his or her step-child if such step child depends on the Employee for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is insured by this Contract as an Employee.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

**DIAGNOSTIC SERVICES.** Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

a. radiology, ultrasound, and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's, and other electronic diagnostic tests.

**DISCRETION.** Our sole right to make a decision or determination.

**DURABLE MEDICAL EQUIPMENT.** Equipment We Determine to be:

a. designed and able to withstand repeated use;
b. used primarily and customarily for a medical purpose;
c. is generally not useful to a Member in the absence of an Illness or Injury; and
d. suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

**EFFECTIVE DATE.** The date on which coverage begins under this Contract for the Employer, to the date coverage begins under this Contract for a Member, as the context in which the term is used suggests.

**EMPLOYEE.** A Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Contract's conditions of eligibility.

**EMPLOYER.** [ABC Company].

**EXPERIMENTAL or INVESTIGATIONAL.**

Services or supplies which We Determine are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving

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health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

**FULL-TIME.** A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

[**GENERIC DRUG.** An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.]

**GOVERNMENT HOSPITAL.** A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

**HOME HEALTH AGENCY.** A Provider which mainly provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

**HOSPICE.** A facility which mainly provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a. be approved for its stated purpose by Medicare; or
b. be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

**HOSPITAL.** A facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a. be accredited as a hospital by the Joint Commission, or
b. be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A facility for the aged or substance abusers is not a Hospital.

**ILLNESS.** A sickness or disease suffered by a Member. A Mental or Nervous Condition is not an illness.

**INITIAL DEPENDENT.** Those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

**INJURY.** Damage to a Member's body due to accident, and all complications arising from that damage.

**INPATIENT.** Member if physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

**JOINT COMMISSION.** The Joint Commission on the Accreditation of Health Care Facilities.

**LATE ENROLLEE.** An eligible Employee or Dependent who requests enrollment under this Contract more than 30 days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** sections of this Contract.

**MEDICAL EMERGENCY.** The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

A near-term delivery is not a Medical Emergency.

**MEDICALLY NECESSARY AND APPROPRIATE.** Services or supplies provided by a recognized health care Provider that We Determine to be:
a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c. in accordance with accepted medical standards in the community at the time;
d. not for a Member's convenience;
e. the most appropriate level of medical care that a Member needs;
f. accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and
g. furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, the fact that an attending doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

**MEDICAID.** The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

**MEDICARE.** Parts A and B of the Health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

**MEMBER.** An eligible person who is covered under this Contract (includes Subscriber/covered Employee and covered Dependents, if any).

**MENTAL HEALTH CENTER.** A facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare.

**MENTAL OR NERVOUS CONDITION.** A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personally disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

**[NETWORK] [PARTICIPATING] PROVIDER.** A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

**NEWLY ACQUIRED DEPENDENT.** An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

**NON-COVERED SERVICES.** Services or supplies which are not included within Our definition of Covered Services or Supplies, or which exceed any of the benefit limits shown in this Contract.

**NON-[NETWORK] [-PARTICIPATING] PROVIDER.** A Provider which is not a [Network] [Participating] Provider.

**NURSE.** A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a. is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b. provides medical services which are within the scope of the nurse's license or certificate and are covered by this Contract.

**OUTPATIENT.** Member if registered at a Practitioner's office or recognized health care facility and not an Inpatient; or services and supplies provided in such a setting.

**PERIOD OF CONFINEMENT.** Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

**PRACTITIONER.** A medical practitioner who:
a. is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b. provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Contract.

[**PRE-EXISTING CONDITION.** An Illness or Injury which manifests itself in the six months before a Member's coverage under this Contract starts, and for which:

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a. A Member sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the Member's coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a Member's coverage starts is also a Pre-Existing Condition.

See the Non-Covered Services and Supplies section of this Contract for details on how this Contract limits the services for Pre-Existing Conditions.]

**PRESCRIPTION DRUGS.** Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

**PRIMARY CARE PHYSICIAN (PCP).** A [Network] [Participating] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

**PROVIDER.** A recognized facility or practitioner of health care.

**REASONABLE and CUSTOMARY.** An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. When We decide what is reasonable, We look at the Member's condition and how severe it is. We also look at special circumstances. The Board will decide a standard for what is Reasonable and Customary under this Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the range of usual fees charged by most Providers of similar training and experience for the same service within the same geographic area.

**REFERRAL.** Specific direction or instruction from A Member's Primary Care Physician in conformance with our policies and procedures that directs a Member to a facility or Provider for health care.

**REHABILITATION CENTER.** A facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a. be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Facilities; or
b. be approved for its stated purpose by Medicare.

**ROUTINE FOOT CARE.** The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

**SERVICE AREA.** A geographic area We defined by [ZIP codes] [county].

**SKILLED NURSING CARE.** Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

**SKILLED NURSING CENTER.** A facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a. be accredited for its stated purpose by the Joint Commission; or
b. be approved for its stated purpose by Medicare.

**SMALL EMPLOYER.** Any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

**SPECIALIST DOCTOR.** A doctor who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

**SPECIALIST SERVICES.** Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for OB/GYN services only)].

**SUBSCRIBER.** A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom Premium has been received.

**SUBSTANCE ABUSE.** Abuse of or addiction to drugs.

**SUBSTANCE ABUSE CENTER.** A facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a. be accredited for its stated purpose by the Joint Commission; or
b. be approved for its stated purpose by Medicare.

**SURGERY.**
a. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;
b. the correction of fractures and dislocations; or
c. pre-operative and post-operative care.

**THERAPEUTIC MANIPULATION.** Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

**THERAPY SERVICES.** The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

**Chelation Therapy**—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

**Chemotherapy**—the treatment of malignant disease by chemical or biological antineoplastic agents.

**Cognitive Rehabilitation Therapy**—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

**Dialysis Treatment**—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

**Infusion Therapy**—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

**Occupational Therapy**—treatment to restore a physicially disabled person's ability to perform the ordinary tasks of daily living.

**Physical Therapy**—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

**Radiation Therapy**—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

**Respiration Therapy**—the introduction of dry or moist gases into the lungs.

**Speech Therapy**—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

**TOTAL DISABILITY OR TOTALLY DISABLED.** Except as otherwise specified in this Contract, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

**WE, US, OUR.** [Carrier].

**YOU, YOUR, AND YOURS.** The Contract Holder.

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## IV. ELIGIBILITY

### EMPLOYEE COVERAGE

**Eligible Employees**

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Contract, all of the Contract Holder's Employees [who are in an eligible class] will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility.**

**Conditions of Eligibility**

**Full-Time Requirement**

[Carrier] will not cover an Employee unless the Employee is an Actively at work Full-Time Employee.

**Enrollment Requirement**

[If an Employee must pay part of the cost of Employee Coverage, We will not cover the Employee until the Employee enrolls and agrees to make the required payments. If the Employee does this:

a. more than 30 days after the Employee first becomes eligible; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

We will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Contract's Pre-Existing Conditions limitation.

However,] if an Employee initially waived coverage under his Contract, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Contract, We will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But the Employee must enroll under this Contract within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

**[The Waiting Period**

This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [3] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [3] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the day after Employees complete [3] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete [3] months of continuous Full-Time service with the Employer.]

**Multiple Employment**

If an Employee works for both the Contract Holder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one firm employs the Employee. And such an Employee will not have multiple coverage under this Contract.

**When Employee Coverage Starts**

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The scheduled Effective Date of an Employee's coverage is a follows:

a. if an Employee must pay part of the cost of Employee coverage, then he or she must elect to enroll and agree to make the required payments within 30 days of his or her eligibility date. If he or she does this within 30 days of his or her eligibility date, his or her coverage is scheduled to start on his or her eligibility date.
b. on non-contributory plans, subject to all the terms of this plan, an Employee's coverage is scheduled to start on his or her eligibility date.]

**When Employee Coverage Ends**

An Employee's coverage under this Contract will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. [the date] an Employee stops being an eligible Employee under this Contract.
c. the date this Contract ends, [or is discontinued for a class of Employees to which the Employee belongs.]
d. [the date] for which required payments are not made for the Employee.
e. [the date] an Employee moves his or her permanent residence outside the Service Area.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Contract's benefits provisions explain these situations. Read this Contract's provisions carefully.

### DEPENDENT COVERAGE

**Eligible Dependents for Dependent Health Benefits**

An Employee's eligible Dependents are:

a. the Employee's legal spouse;
b. the Employee's unmarried Dependent children who are under age 19; and
c. the Employee's unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be defined by the accredited school.

**Adopted Children and Step-Children**

An Employee's "unmarried Dependent children" include the Employee's legally adopted children, if they depend on the Employee for most of their support and maintenance, his or her step-children and children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

Eligible Dependents will not include any Dependent who is:

a. covered by this Contract as an Employee or
b. on active duty in the armed forces of any country.

**Incapacitated Children**

An Employee may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past this Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Contract's age limit;
b. the child became covered by this Contract before the child reached the age limit, and stayed continuously covered until reaching such limit; and
c. the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send Us written proof that the child is handicapped and depends on the Employee for most support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

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**Enrollment Requirement**

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Contract. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:

a. enrolls a Dependent [and agrees to make the required payments] after the end of the enrollment period;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Contract's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Contract because they were covered under another group plan, and the Employee now elects to enroll them in this Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur.

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Contract, to be a Late Enrollee, if:

a. the Employee is under legal obligation to provide coverage due to a court order; and
b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

**When Dependent Coverage Starts**

In order for an Employee's dependent coverage to begin the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of this Contract, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents [and agrees to make any required payments].

If the Employee does this on or before the Employee's eligibility date, the Dependent's Coverage is scheduled to start on the later of:

a. the Employee's eligibility date, or
b. the date the Employee becomes covered for Employee coverage.

If the Employee does this within or after the enrollment period, the coverage is scheduled to start on the later of:

a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes covered for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify Us of a Newly Acquired Dependent within the enrollment period. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent will be covered from the later of:

a. the date the Employee notifies [Carrier] [and agrees to make any additional payments], or
b. the date the Newly Acquired Dependent is first eligible.

**Exception:** If a Dependent, other than a newborn child, is confined to a Hospital or other health care facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such facility; until home confinement ends.

**Newborn Children**

We will cover an Employee's newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:

a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid.]
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child[; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.]

If the request is not made[ and the premium is not paid] within such 31 day period, the newborn child will be a Late Enrollee.

**When Dependent Coverage Ends:**

A Dependent's coverage under this Contract will end on the first of the following dates:

a. [the date] Employee coverage ends;
[b. the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c.] the date this Contract ends;
[d.] the date Dependent coverage is dropped from this Contract for all Employees eligible for such coverage;
[e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f.] the date the Dependent stops being an eligible Dependent. This happens at 12:01 a.m. on the date:
   - the child attains the Contract's age limit;
   - the Dependent child marries;
   - a step-child is no longer dependent on the Employee for support and maintenance;
   - a spouse's marriage ends in legal divorce or annulment.

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted policies.

**TERMINATION FOR CAUSE**

If any of the following conditions exist, We may give written notice to the Member that the person is no longer covered under this Contract:

(1) **Untenable Relationship:** After reasonable efforts, We and/or [Participating] Providers are unable to establish and maintain a satisfactory relationship with the Member or the Member fails to abide by our rules and regulations, or the Member acts in a manner which is verbally or physically abusive.
(2) **Misuse of Identification Card:** The Member permits any other person who is not authorized by Us to use an identification card We issue to the Member.
(3) **Furnishing Incorrect or Incomplete Information:** The Member furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the section Incontestability of Coverage.
(4) **Nonpayment:** The Member fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.
(5) **Misconduct:** The Member abuses the system, including but not limited to; theft, damage to [Our] [Participating Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
(6) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the Coordination of Benefits Section.

If We give the Member such written notice:

(a) that person will cease to be a Member for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (2 above) or **Misconduct** (5 above), otherwise, on the date 31 days after such written notice is given by Us; and
(b) no benefits will be provided to the Member under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Grievance Procedures We establish.

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## V. COVERED SERVICES AND SUPPLIES

Members are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by Members of applicable copayments [or co-insurance] as stated in the applicable Schedule of Services.

a. **Outpatient Benefits.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a Member, or elsewhere upon prior written Referral by a Member's Primary Care Physician:
   1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
   2. **Home visits** by a Member's Primary Care Physician.
   3. **Periodic health examinations** to include:
      a. Well child care from birth including immunizations;
      b. Routine physical examinations, including eye examinations;
      c. Routine gynecologic exams and related services;
      d. Routine ear and hearing examination; and
      e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a Member's employment).
   4. **Diagnostic Services.**
   5. **Casts and dressings.**
   6. **Ambulance Service** when certified in writing as Medically Necessary by a Member's Primary Care Physician and approved in advance by Us.
   7. **Infertility Services** except where specifically excluded in this Contract.
   8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
   9. **Durable Medical Equipment** when ordered by a Member's Primary Care Physician and arranged through Us.
   10. **Prescription Drugs** when obtained through a Participating Provider.

b. **SPECIALIST DOCTOR BENEFITS.** The following Services are covered when rendered by a Participating Specialist Doctor at the doctor's office[, or Health Center,] or any other Participating Facility or a Participating Hospital outpatient department during office or business hours upon prior written referral by a Member's Primary Care Physician. Services include but are not limited to the following:
   1. Allergy (except serum injections which are covered when administered by a Member's Primary Care Physician)
   2. Anesthesia
   3. Cardiology
   4. Endocrinology
   [5. Gynecology and Obstetrics]
   6. Internal Medicine
   7. Neurology
   8. Oncology
   9. Ophthalmology
   10. Oral Surgery (bone fractures, removal of tumors and orthodontogenic cysts or other approved surgical procedures by Us)
   11. Orthopedics
   12. Otolaryngology
   13. Pathology
   14. Pediatrics
   15. Podiatry
   16. Pulmonology
   17. Radiology (except dental x-rays, unless related to Covered Services)
   18. Surgery
   19. Urology

c. **INPATIENT HOSPITAL AND SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center benefits are limited to those which constitute Skilled Nursing Care:
   1. Semi-private room and board accommodations
   2. Private accommodations [will be provided only when approved in advance by Us]. If a Member occupies a private room without such certification Member shall be directly liable to the Hospital or Skilled Nursing Center for the difference between payment by Us to the Hospital or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospital or the Participating Skilled Nursing Center and the private room rate.
   3. General nursing care
   4. Use of intensive or special care facilities
   5. X-ray examinations including CAT scans but not dental x-rays
   6. Use of operating room and related facilities
   7. Magnetic resonance imaging
   8. Drugs, medications, biologicals
   9. Cardiography/Encephalography
   10. Laboratory testing and services
   11. Pre- and post-operative care
   12. Special tests
   13. Nuclear medicine
   14. Therapy Services
   15. Oxygen and oxygen therapy
   16. Anesthesia and anesthesia services
   17. Blood, blood products and blood processing
   18. Intravenous injections and solutions
   19. Surgical, medical and obstetrical services
   20. Private duty nursing only when approved in advance by Us.
   21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas
   22. Allogeneic bone marrow transplants
   23. The autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich).

d. **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center [or Health Center] upon prior written referral by a Member's Primary Care Physician.
   1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are additionally eligible, upon referral by a Member's Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
   2. **Inpatient Hospital Care.** Members are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

      **Chemical Dependency Admissions.** Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole discretion it is determined that Members have been cooperative with an on-going treatment plan de-

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veloped by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services.

3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

e. **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by a Member's Primary Care Physician in the event of a Medical Emergency as determined by Us.

1. A Member's Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Physician [or Health Center] [or Us] prior to seeking emergency treatment.
2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:
   a. Our review determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention. Conditions which require immediate treatment include, but are not limited to the following:
      1. heart attacks
      2. strokes
      3. convulsions
      4. serious burns
      5. obvious bone fractures
      6. wounds requiring sutures
      7. poisoning
      8. loss of consciousness

      A near-term delivery is not a Medical Emergency.
   b. The service rendered is provided as a benefit under this Contract and is not a service which is normally treated on a non-emergency basis; and
   c. We and a Member's Primary care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. Member shall be responsible for payment for services received unless We determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event Members are hospitalized in a Non-participating facility, coverage will only be provided until Members are medically able to travel or to be transported to a Participating facility. If Members elect to continue treatment with Non-participating Providers, We shall have no responsibility for payment beyond the date Members are determined to be medically able to be transported.

   In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by Members of all Copayments which would have been required had similar benefits been provided during office hours and upon prior written referral to Participating Provider.
4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after Members have been admitted to a facility as the result of a Medical Emergency shall require prior written referral or Member shall be responsible for payment.
5. The Copayment for an emergency room visit will not apply in the event that Members are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

f. **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by a Member's Primary Care Physician.

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a Participating Provider by a Member's Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a Member's Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a Member's condition within this time period and treatment is approved in writing by Us.
2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy and Radiation Therapy.

g. **HOME HEALTH BENEFITS.** The following Services are covered when rendered by a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a Member's Primary Care Physician.

1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.
2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to Member is skilled in nature.
3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a Member's medical condition.
4. Therapy Services as set forth above.
5. Hospice Care if Members are terminally ill with life expectancy of six months or less, as certified by the Member's Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members; inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate Care.

## VI. NON-COVERED SERVICES AND SUPPLIES

**THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.**

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless Member is being transferred to another Inpatient health care Facility.

**[Broken Appointments.]**

**Blood or blood plasma** which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

**Completion of claim forms.**

Services or supplies related to **cosmetic surgery,** except as otherwise stated in this Contract, unless it is required as a result of an Injury sustained while covered under this Contract or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

**Dental care** or treatment, including appliances, except as otherwise stated in this Contract.

Services or supplies, the primary purpose of which is **educational** providing the Member with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

**Experimental or Investigational** treatments, procedures, hospitalizations, drugs, biological products or medical devices.

**Extraction of teeth,** except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

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Services or supplies provided by one of the following members of the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance **fertility** using artificial and surgical procedures and drugs, including, but not limited to, invitro fertilization, invivo fertilization or gamete-intrafalopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to **Hearing aids, hearing examinations** or fitting of hearing aids.

Services or supplies related to **Herbal medicine.**

Care or treatment by means of **high dose chemotherapy,** except as otherwise stated in the Contract.

Services or supplies related to **Hypnotism.**

Services or supplies because the Covered Person engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit a felony.

**Illness or Injury,** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

**Local anesthesia** charges billed separately if such charges are included in the fee for the Surgery.

**Membership costs** for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Contract, or which is **not Medically Necessary and Appropriate.**

**Non-prescription drugs** or supplies, except insulin needles and insulin syringes.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious.

**Personal convenience** or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

**[Pre-Existing Condition Limitations:** We do not cover services for Pre-Existing Conditions until Members have been covered by this Contract for six months. See the "Definitions" section of this Contract for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for A Member's Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which covered Member right before the Member's coverage under this Contract started, i.e., there is no intervening lapse in coverage.]

Any service provided without prior written Referral by the Member's **Primary Care Physician** except as specified in this Contract.

In the event of a Medical Emergency, the amount of any charge which is greater than a **Reasonable and Customary Charge.**

Services or supplies related to **rest or convalescent cures.**

**Room and board charges** for a Member in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Services or supplies related to **Routine Foot Care.**

**Self-administered services** such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

**Services or supplies:**

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Member asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Member would not have been charged if he or she did not have health care coverage;
d. provided by or in a Government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury.

**Smoking cessation aids** of all kinds and the services of stop-smoking providers.

**Sterilization reversal**—services and supplies rendered for reversal of sterilization.

**Surgery,** sex hormones, and related medical, psychological and psychiatric services to change a Member's sex; services and supplies arising from complications of sex transformation.

**Telephone consultations.**

**Transplants,** except as otherwise listed in the Contract.

**Transportation;** travel.

**Vision therapy.**

**Vitamins and dietary supplements.**

Services or supplies received as a result of a **war,** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

**Weight reduction or control,** unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

**Wigs, toupees, hair transplants, hair weaving or any drug** used in connection with baldness.

## VII. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

## VIII. COORDINATION OF BENEFIT

### COORDINATION OF BENEFITS

**Purpose Of This Provision**

A Member may be covered for health benefits by more than one plan. For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays. We do this so the Member does not collect more in benefits that he or she incurs in charges.

### DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. group or group-type hospital indemnity benefit which exceed $150.00 per day.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits of $150.00 per day or less; and
d. any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Member", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits.

"Dependent" means a person who is covered by a plan for health benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefit is less than or equal to the reduction that would have been made under the terms if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or

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services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

**How This Provision Works**

We apply this provision when a member or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.
   - When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
   - If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
   - The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

**Our Right To Certain Information**

In order to coordinate benefits, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

**[Small Claims Waiver**

We do not coordinate claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

**BENEFITS FOR AUTOMOBILE RELATED INJURIES**

This section will be used to determine a person's benefits under this Contract when services are incurred as a result of an automobile related Injury.

**Definitions**

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. this Contract;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

**Determination of primary or secondary coverage.**

This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one Member, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits as if it were primary.

**Benefits this Contract will pay if it is primary to PIP or OSAIC.**

If this Contract is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Contract will apply if:

- the Member is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.

If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payment, or
b. the benefits that would have been paid if this Contract has been primary.

## IX. CONTRACT HOLDER GENERAL PROVISIONS

**AMENDMENTS**

The Contract may be amended, at any time, without a Member's consent or of anyone else with a beneficial interest in it. The Contract Holder may change the type of coverage under this Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contract Holder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be

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paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:

a. it is shown in an endorsement on it signed by one of Our officers.
b. if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called "Conformity With Law," it is shown in an amendment to it that is signed by one of Our officers.
c. if a change is required by Us, it is accepted by the Contract Holder, as evidenced by payment of a Premium on or after the effective date of such change.
d. if a written request for a change is made by the Contract Holder, it is shown in an amendment to it signed by the Contract Holder and by one of Our Officers.

**ASSIGNMENT**

No assignment or transfer by the Contract Holder of any of the Contract Holder's interest under this Contract is valid unless We consent thereto.

**CLERICAL ERROR—MISSTATEMENTS**

No clerical error by Us in keeping any records pertaining to Coverage under this Contract will reduce a Member's Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

**CONFORMITY WITH LAW**

Any provision of this Contract which, on its Effective Date, is in conflict with the statutes of the state in which the Member resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

**CONTINUING RIGHTS**

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

**CONTRACT INTERPRETATION**

We shall administer Contract in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

**[CONVERSION PRIVILEGE**

If an Employee's Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.]

**GOVERNING LAW**

This entire Contract is governed by the laws of the State of New Jersey.

**INCONTESTABILITY OF THE CONTRACT**

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with Fraudulent statements.

If this Contract replaces the contract of another insurer, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

**NOTICES AND OTHER INFORMATION**

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to the Contract Holder: To the last address provided by the Contract Holder on an enrollment or change of address form actually delivered to Us.

**OTHER RIGHTS**

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Contract Holder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplication of it is attached to this Contract or has been furnished to the Contract Holder for attachment to this Contract.

**PREMIUM AMOUNTS**

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect and the Employees then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Contract Holder and Us.

The following will apply if one or more Premiums paid include Premium charges for a Member whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

a. the amounts of the Premium charges for the Member that were included in the Premiums paid for the two-month period immediately before the date We receive written notice from the Contract Holder that the Member's coverage has ended.
b. the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.

**PAYMENT OF PREMIUMS—GRACE PERIOD**

Premiums are to be paid by the Contract Holder to Us. They are due on each Premium Due Date stated on the first page of the Contract. The Contract Holder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contract Holder is liable to pay Premiums to Us from the first day the Contract is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

**PREMIUM RATE CHANGES**

The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Contract. We have the right to change Premium rates as of any of these dates:

a. any Premium Due Date;
b. any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. any date that the extent or nature of the risk under the Contract is changed:
   1. by amendment of the Contract; or
   2. by reason of any provision of law or any government program or regulation;
d. at the discovery of a clerical error or misstatement as described below.
e. As of the date the nature of the Contract Holder's business changes.

We will give You 30 days written notice when a change in the Premium rates is made.

**TERMINATION OF THE CONTRACT—RENEWAL PRIVILEGE**

We have the right to cancel this Contract on any premium due date subject to 30 days advance written notice to the Contract Holder for the following reasons:

a. During or End of Grace Period—Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Contract Holder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Contract will end on the date requested.
b. the Policyholder moves its principal place of business outside the State of New Jersey;

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c. subject to the statutory notification requirements, We cease to do business in the small group market;
d. with respect to Contributory Contracts, less than [75%] of the Employer's eligible Employees are covered by this Contract. (If an eligible Employee is not covered by this Contract because:
   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under an alternate benefits plan offered by the Contract Holder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.); or
e. with respect to Non-contributory Contracts, less than [75%] of the Employer's eligible Employees are covered by this Contract. (If an eligible Employee is not covered by this Contract because:
   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under an alternate health benefits plan offered by the Contract Holder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Contract Holder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

This Contract is issued for a term of one (1) year from the Effective Date shown on the first page of this Contract. All Contract Years and Contract Months will be calculated from the Effective Date. All periods of coverage hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time at the Contract Holder's place of business.

The Contract Holder may renew this Contract for a further term of one (1) year, on the first and each subsequent Contract Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's Premium Amounts section.

However, We have the right to non-renew this Contract on any Contract Anniversary if the Contract Holder is no longer a Small Employer.

The Employer must certify to Us the Employer's status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If Employer fails to do this, We retain the right to take the actions described above as of the Employer's Contract Anniversary.

[Also, if the nature of the Employer's business changes, the Employer must notify Us within 30 days. We have the right to change the rates We charge for this Contract if this happens. If the Employer fails to notify Us within 30 days, We have the right to adjust premium rates retroactively to the date the nature of the Employer's business changed.] **[Note: This section will sunset January 1, 1997]**

**THE CONTRACT**

The entire Contract consists of:
[a. the forms shown in the Table of Contents as of the Effective Date;
b.] the Contract Holder's application, a copy of which is attached to the Contract;
[c.] any riders, [endorsements] or amendments to the Contract; and
[d.] the individual applications, if any, of all Members.

## X. MEMBER GENERAL PROVISIONS

**ASSIGNMENT**

No assignment or transfer by a Member of any of his or her interest under this Contract is valid unless We consent thereto.

**CONFIDENTIALITY**

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us may not be disclosed without the Member's written consent, except as required by law.

**CONTINUING RIGHTS**

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

**CONVERSION PRIVILEGE**

If a Member's Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

**GOVERNING LAW**

This entire Contract is governed by the laws of the State of New Jersey.

**IDENTIFICATION CARD**

The Identification Card issued by Us to Members pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are Members. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Grievance Procedures.

**INABILITY TO PROVIDE SERVICE**

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

**INCONTESTABILITY OF THE CONTRACT**

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

If this Contract replaces the contract of another insurer, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

**INDEPENDENT CONTRACTOR RELATIONSHIP**

1. No Participating Provider or other provider, institution, facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any Participating Provider or other provider, institution, facility or agency.
2. Neither the Contract Holder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.
3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Contract Holder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

**LIMITATION OF ACTIONS**

No action at law or in equity shall be brought to recover on the Contract until 60 days after a Member files written proof of loss. No

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such action shall be brought more than three years after the end of the time within which proof of loss is required.

**LIMITATION ON SERVICES**

Except in cases of Medical Emergency, services are available only from Participating Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

**MEDICAL NECESSITY**

Members will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We may determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by [our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Contract that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Contract.

**NOTICES AND OTHER INFORMATION**

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to a Member: to the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

**OTHER RIGHTS**

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Member's application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to a Member for attachment to this Contract.

**CONTRACT INTERPRETATION**

We shall administer Contracts in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

**REFERRAL FORMS**

A Member can be referred for Specialist Services by a Member's Primary Care Physician.

**Member will be responsible for the cost of all services provided by anyone other than a Member's Primary Care Physician (including but not limited to Specialist Services) if a Member has not been referred by his or her Primary Care Physician.**

**REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION**

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor We, or any Participating Provider will have further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

**REPORTS AND RECORDS**

We are entitled to receive from any provider of services to Member such information We deem is necessary to administer this Contract subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, Contract Holder, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Us upon request and to permit copying of Member's records by us.

**SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]**

When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

Members select a Primary Care Physician from Our [Practitioners Directory]; this choice is solely a Member's. However, We cannot guarantee the availability of a particular doctor. If the Primary Care Physician initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Physician selection.

[After initially selecting a Primary Care Physician, Members can transfer to different Primary Care Physicians if the physician patient relationship becomes unacceptable. The member can select another Primary Care Physician from Our [Practitioners Directory].

Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If we receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

**STATEMENTS**

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the Member or to the Member's beneficiary.

All statements will be deemed representations and not warranties.

**TERMINATION OF DEPENDENT COVERAGE**

If an Employee fails to pay the cost of Dependent coverage, an Employee's Dependent coverage will end. It will end on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date he attains the Contract's age limit, or marries, or when a step-child is no longer dependent on the Employee for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when the Employee's coverage ends.

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

**THE ROLE OF A MEMBER'S PRIMARY CARE PHYSICIAN**

A Member's Primary Care Physician provides basic health maintenance services and coordinates a Member's overall health care. Anytime a Member needs medical care, the Member should contact his or her Primary Care Physician and identify himself or herself as a Member of this program.

In a Medical Emergency, a Member may go directly to the emergency room. If a Member does, then the Member must call his or her Primary Care Physician and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

**[THE ROLE OF THE CARE MANAGER.** The Care Manager will manage a Member's treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse. A Member must contact the Care Manager or the Member's Primary Care Physician when a Member needs treatment for one of these conditions.]

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## XI. CONTINUATION RIGHTS

### COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Member may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR):** If a Member is eligible to continue his or her group health benefits under both this Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Contract:

If a Member elects to continue his or her group health benefits under both this Contract's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

When covered under more than one continuation section, the Member:

a. will not be entitled to duplicate benefits; and
b. will not be subjected to the premium requirements of more than one section at the same time.

### AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

**The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:**

**a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, and therefore;**
**b. the section applies to the Employee.**

### COBRA CONTINUATION RIGHTS

#### Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Contract during a continuation provided by this section is not qualified continuee.

#### If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:

a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

#### Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

#### If An Employee Dies While Covered

If an Employee dies while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

#### If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

#### If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to the **When Continuation Ends.**

#### Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

#### The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Contract, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

#### The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue this Contract's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hour; or
b. the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered Dependent child.

#### The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

#### Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue.

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This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

**Grace in Payment of Premiums**

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

**When Continuation Ends**

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date this Contract ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this Contract's Conversion Rights for Divorced Spouses section for details.

## NEW JERSEY GROUP CONTINUATION RIGHTS

**Important Notice**

**If An Employee's Group Benefits End**

If an Employee's health coverage end due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

**What The Employee Must Do**

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

**The Continued Coverage**

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Contract on a regular basis. Any modifications made under this Contract will apply to similarly situated continuees. We do not ask for proof for insurability in order for an Employee to continue.

**When Continuation Ends**

A Member's continued health coverage end on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Member becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Member becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;
e. with respect to a Member who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Contract.

## A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

**If An Employee is Totally Disabled**

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

**How And When To Continue Coverage**

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

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**When This Continuation Ends**

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying.
b. the date the Member becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

**EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE**

**Important Notice**

**This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:**

- the Employer must allow for a leave of absence under Federal law and, therefore
- the section applies to the Employee.

**If An Employee's Group Health Coverage Ends**

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

**When Continuation Ends**

Insurance may continue until the earliest of:

a. the date the Employee returns to Full-Time work
b. the end of a total period of 12 weeks in any 12 month period, or
c. the date on which the Employee's coverage would have ended had the Employee not been on leave.

**A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS**

If an Employee dies, any of his or her Dependents who were insured under this Contract may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Contract.

**CONVERSION RIGHTS FOR DIVORCED SPOUSES**

**IF AN EMPLOYEE'S MARRIAGE ENDS**

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Contract on the date the group health coverage ends. See exceptions below.

**Exceptions**

No former spouse may use this conversion right:

- unless he or she has been insured under this Contract for at least 3 months;
- if he or she is eligible for Medicare;
- if it would cause him or her to be overinsured; or
- [if he or she permanently relocates outside the Service Area.]

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if overinsurance exists using Our standards for overinsurance.

**HOW AND WHEN TO CONVERT**

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

**THE CONVERTED CONTRACT**

The individual policy will provide the medical benefits that We are required to offer. The individual policy will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Contract. If so, benefits to be paid under the individual policy will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.

**XII. RIGHT TO RECOVERY—THIRD PARTY LIABILITY**

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

**XIII. EFFECT OF MEDICARE ON THE COVERAGE**

**A. ELIGIBILITY PROVISIONS FOR MEMBERS AGE 65 OR MORE WHO ARE ELIGIBLE FOR MEDICARE.**

"Medicare" means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Member age 65 or more who is eligible for Part A of Medicare may have this coverage as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The Group Health Care Coverage for such Member will continue only while the Member is meeting the following conditions:

1. In the case of an Employee, the Employee is not retired.
2. In the case of a Qualified Dependent, the Member is the Qualified Dependent of an Employee who meets condition (1) above.
3. The Member has not elected Medicare, in writing, as the primary benefit program.

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**B. SPECIAL PROVISIONS FOR OTHER MEMBERS WHO ARE ELIGIBLE FOR MEDICARE.**

For a member who is eligible for Medicare and to whom section A above does not apply, this coverage will continue only subject to the following conditions:

1. The Member, if eligible, has enrolled in Parts A and B of Medicare.
2. The Member has completed such consents, releases, assignments and other documents reasonably requested by Us to obtain or assure Medicare reimbursements.

**C. BENEFITS.**

The benefits of this coverage provided to Members are not designed to duplicate any benefit for which they are enrolled and entitled under Medicare. All sums payable under Medicare for services and supplies that are provided under this coverage will be payable to, and retained by, Us.

**EXHIBIT H**

**PART 1**

**RIDER FOR PRESCRIPTION DRUG INSURANCE**

**Policyholder:**

**Group Policy No:**

**Effective Date:**

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration. In no event will [Carrier] pay for drugs labeled: "Caution—Limited by Federal Law to Investigational Use". And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

**DEFINITIONS**

**Brand Name Drugs** mean:

a. drugs as determined by the Food and Drug Administration and listed in the Forumulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

**Generic Drugs** mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

**Mail Order Program** means a program agreed to by [ABC] and a Participating Pharmacy under which a Covered Person can obtain Maintenance Drugs from a Participating Pharmacy by ordering the drugs through the mail.

**Maintenance Drug** means only a Prescription Drug used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only), glaucoma; hypertension; thyroid disease; seizure disorders.

**Participating Pharmacy** means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

**Prescription Drug** means:

a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

**Legend Drugs** means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

**CO-PAYMENT**

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is **not** obtained through the Mail Order Program is:

- for Generic Drugs $5.00
- for Brand Name Drugs $10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drug None
- for Brand Name Drugs $5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

**COVERED DRUGS**

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);
b. dispensed by a participating Pharmacy;
c. needed to treat an Illness or Injury; and
d. accepted as safe and effective by the health community.

Such charges will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b. a 90 day supply of a Maintenance Drug obtained through the Mail Order Program; and
c. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

**POLICYHOLDER LIABILITY**

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

**EXCLUSIONS**

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.
b. Charges for:
   - immunization agents
   - biological sera
   - blood or blood plasma.
c. Charges for a Prescription Drug which is:
   - labeled "Caution—limited by Federal Law to investigational use"; or
   - experimental.
d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - an Extended Care Facility
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution
h. Charges for:
   - therapeutic devices or appliances
   - hypodermic needles
   - syringes
   - support garments

   and other non-medical substances, regardless of their intended use.

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i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs containing nicotine or other smoking deterrent medication.
k. Charges for topical dental Fluorides.
l. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
m. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
n. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
o. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
p. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

**EXHIBIT H**

**PART 2**

**RIDER FOR PRESCRIPTION DRUG INSURANCE**

**Policyholder:**

**Group Policy No:**

**Effective Date:**

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration. In no event will [Carrier] pay for drugs labeled: "Caution—Limited by Federal Law to Investigational Use". And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner: What [Carrier] pays and the terms of payment are explained below.

**DEFINITIONS**

**Brand Name Drugs** mean:
a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

**Generic drugs** mean:
a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength of concentration, dosage form and route of administration.

**Participating Pharmacy** means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

**Prescription Drug** means:
a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

**Legend Drugs** means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

**CO-PAYMENT**

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs $5.00
- for Brand Name Drugs $10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

**COVERED DRUGS**

The Policy only pays benefits for Prescription Drugs which are:
a. prescribed by a Practitioner (except for insulin);
b. dispensed by a Participating Pharmacy;
c. needed to treat an Illness or Injury; and
d. accepted as safe and effective by the health community.

Such charges will not include charges made for more than:
a. the greater of a 30 day supply or 100 unit doses; and
b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

**POLICYHOLDER LIABILITY**

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

**EXCLUSIONS**

[Carrier] will not pay for any of the following:
a. Charges to administer a Prescription Drug.
b. Charges for:
   - immunization agents
   - biological sera
   - blood or blood plasma.
c. Charges for a Prescription Drug which is:
   - labeled "Caution—limited by Federal Law to investigational use"; or
   - experimental.
d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Presciption Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - an Extended Care Facility
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution.
h. Charges for:
   - therapeutic devices or appliances
   - hypodermic needles
   - syringes
   - support garments

   and other non-medical substances, regardless of their intended use.
i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs containing nicotine or other smoking deterrent medication.
k. Charges for topical dental Fluorides.
l. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil

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disorder; or the Covered Person taking part in the commission of a felony.

m. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
n. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
o. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
p. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

**EXHIBIT H**

**PART 3**

**RIDER FOR PRESCRIPTION DRUG INSURANCE**

**Policyholder:**

**Group Policy No:**

**Effective Date:**

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration. In no event will [Carrier] pay for drugs labeled: "Caution—Limited by Federal Law to Investigational Use". And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

**DEFINITIONS**

**Brand Name Drugs** mean:

a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

**Generic drugs** mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

**Mail Order Program** means a program agreed to by [ABC] and a Participating Pharmacy under which a Covered Person can obtain Maintenance Drugs from a Participating Pharmacy by ordering the drugs through the mail.

**Maintenance Drug** means only a Prescription Drug used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only), glaucoma; hypertension; thyroid disease; seizure disorders.

**Participating Pharmacy** means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

**Prescription Drug** means:

a. Legend Drugs
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

**Legend Drugs** means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

**CO-PAYMENT**

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

**COVERED DRUGS**

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);
b. dispensed by a Participating Pharmacy for take-home use;
c. needed to treat an Illness or Injury; and
d. accepted as safe and effective by the health community.

Such charges will not include charges made for more than:

a. a 90 day supply of a Maintenance Drug obtained through the Mail Order Program; and
b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

**POLICYHOLDER LIABILITY**

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

**EXCLUSIONS**

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.
b. Charges for:
   - immunization agents
   - biological sera
   - blood or blood plasma.
c. Charges for a Prescription Drug which is:
   - labeled "Caution—limited by Federal Law to investigational use"; or
   - experimental.
d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - an Extended Care Facility
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution.
h. Charges for:
   - therapeutic devices or appliances
   - hypodermic needles
   - syringes
   - support garments

   and other non-medical substances, regardless of their intended use.
i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs containing nicotine or other smoking deterrent medication.
k. Charges for topical dental Fluorides.

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l. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
m. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
n. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
o. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
p. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

**EXHIBIT I**

**RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS**

**Policyholder:**

**Group Policy No:**

**Effective Date:**

The **Mental and Nervous Conditions and Substance Abuse** section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following.

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

**PRE-CERTIFICATION REQUIREMENTS**

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and precertifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] reduces what it pays for care and treatment of Mental and Nervous conditions and Substance Abuse as a penalty. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

**NON-EMERGENCY SITUATIONS**

All non-emergency care or treatment **must** be reviewed by [XYZ] **before** it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

**EMERGENCY SITUATIONS**

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

**Emergency** means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:
a. the Medical Necessity and Appropriateness;
b. the type of service involved;
c. the appropriate level of care required; and
d. the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

**BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE**

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

**Co-Insurance**

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a provider.

| | |
|---|---|
| For Inpatient services certified by [XYZ] | None |
| For Inpatient services not certified by [XYZ] | 100% |
| For Outpatient services certified by [XYZ] | None |
| For Outpatient services not certified by [XYZ] | 100% |

**Co-Payments**

Each Covered Person must pay a Co-Payment of $150 for each day of Inpatient care up to a maximum of $750 per confinement, subject to a maximum of $1,500 Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15] to the [XYZ] referred provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

**Benefit Limits**

Under this rider, [Carrier] only covers:
a. 30 days of Inpatient care per Calendar year; and
b. 20 Outpatient visits per Calendar year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

**PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS**

As a penalty for non-compliance with pre-certification requirements, [Carrier] reduces what it pays for Covered Charges to 50% of what it would otherwise pay if:
a. the Covered Person does not request a review in the times and manner described above;
b. the Covered Person's treatment does not comply with the treatment plan;
c. the Covered Person goes to a provider whose services were not referred by [XYZ]; or
d. [XYZ] does not confirm the need for such care or treatment.

**APPEALS PROCEDURE**

If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

**EXHIBIT J**

**PART 1**

**RIDER FOR PRESCRIPTION DRUG COVERAGE**

**Contract Holder:**

**Group Contract No:**

**Effective Date:**

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

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We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are approved for treatment of the Member's Illness or Injury by the Food and Drug Administration. In no event will We pay for drugs labeled: "Caution—limited by Federal Law to Investigational Use". And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

**DEFINITIONS**

**Brand Name Drugs** mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. protected by the trademark registration of the pharmaceutical company which produces them.

**Generic Drugs** mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed:
b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

**Mail Order Program** means a program agreed to by [ABC] and a Participating Pharmacy under which a Member can obtain Maintenance Drugs from a Participating Pharmacy by ordering the drugs through the mail.

**Maintenance Drug** means only a Prescription Drug used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only), glaucoma; hypertension; thyroid disease; seizure disorders.

**Participating Pharmacy** means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

**Prescription Drug** means:

a. Legend Drugs
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

**Legend Drugs** means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

**Copayment**

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill which is **not** obtained through the Mail Order Program is:

- for Generic Drugs $5.00
- for Brand Name Drugs $10.00

The Copayment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

**COVERED DRUGS**

The Contract only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin)
b. dispensed by a Participating Pharmacy;
c. needed to treat an Illness or Injury; and
d. accepted as safe and effective by the health community.

Such prescription or refill will not include a prescription or refill that is more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b. a 90 day supply of a Maintenance Drug obtained through the Mail Order Program; and
c. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

**Contract Holder Liability**

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends, except as stated in the **Extended Health Benefit** section of the Contract.

**NON-COVERED SERVICES AND SUPPLIES**

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use" or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs containing nicotine or other smoking deterrent medication.
m. Topical dental Fluorides.
n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p. Drugs dispensed to a Member while on active duty in any armed force.
q. Drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r. Drugs needed due to an on-the-job related Injury or Illness; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

**[Carrier should insert Standard Rider]**

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EXHIBIT J

PART 2

RIDER FOR PRESCRIPTION DRUG COVERAGE

**Contract Holder:**

**Group Contract No:**

**Effective Date:**

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are approved for treatment of the Member's Illness or Injury by the Food and Drug Administration. In no event will We pay for drugs labeled: "Caution—limited by Federal Law to Investigational Use". And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

**Brand Name Drugs** mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. protected by the trademark registration of the pharmaceutical company which produces them.

**Generic Drugs** mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

**Participating Pharmacy** means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

**Prescription Drug** means:

a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

**Legend Drugs** means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

**Copayment**

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:

- for Generic Drugs $5.00
- for Brand Name Drugs $10.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);
b. dispensed by a Participating Pharmacy;
c. needed to treat an Illness or Injury; and
d. accepted as safe and effective by the health community.

Such prescription or refill will not include a prescription or refill that is more than amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

**Contract Holder Liability**

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends, except as stated in the **Extended Health Benefit** section of the Contract.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use" or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs containing nicotine or other smoking deterrent medication.
m. Topical dental Fluorides.
n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p. Drugs dispensed to a Member while on active duty in any armed force.
q. Drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r. Drugs needed due to an on-the-job related Injury or Illness; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

**[Carrier should insert Standard Rider]**

EXHIBIT J

PART 3

RIDER FOR PRESCRIPTION DRUG COVERAGE

**Contract Holder:**

**Group Contract No:**

**Effective Date:**

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are approved for treatment of the Member's Illness or Injury by the Food and Drug Administration. In no event will We pay for drugs labeled: "Caution—limited by Federal Law to Investigational Use". And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

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This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

**DEFINITIONS**

**Brand Name Drugs** mean:
a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. protected by the trademark registration of the pharmaceutical company which produces them.

**Generic Drugs** mean:
a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

**Mail Order Program** means a program agreed to by [ABC] and a Participating Pharmacy under which a Member can obtain Maintenance Drugs from a Participating Pharmacy by ordering the drugs through the mail.

**Maintenance Drug** means only a Prescription Drug used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only), glaucoma; hypertension; thyroid disease; seizure disorders.

**Participating Pharmacy** means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

**Prescription Drug** means:
a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

**Legend Drugs** means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

**Copayment**

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

**COVERED DRUGS**

The Contract only provides benefits for Prescription Drugs which are:
a. prescribed by a Participating Provider (except for insulin)
b. dispensed by a Participating Pharmacy;
c. needed to treat an Illness or Injury; and
d. accepted as safe and effective by the health community.

Such prescription or refill will not include a prescription or refill that is more than:
a. a 90 day supply of a Maintenance Drug obtained through the Mail Order Program; and
b. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

**Contract Holder Liability**

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends, except as stated in the **Extended Health Benefit** section of the Contract.

**NON-COVERED SERVICES AND SUPPLIES**

We will not provide for any of the following Services or Supplies:
a. Administration of a Prescription drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use" or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs containing nicotine or other smoking deterrent medication.
m. Topical dental Fluorides.
n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p. Drugs dispensed to a Member while on active duty in any armed force.
q. Drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.
r. Drugs needed due to an on-the-job or job related Injury or Illness; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

**[Carrier should insert Standard Rider]**

**EXHIBIT K**

**PART 1**

**EXPLANATION OF BRACKETS (PLANS A, B, C, D, E)**

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.
a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC].
b. Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.
c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in the policy forms.
1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that are organized as mutual companies.
2. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
3. The refund formula specified on the Premium Amounts provision of the General Provisions may be modified to specify alternate methods of calculation.

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4. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy—Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
5. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
6. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Carrier. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.
7. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.

## EXHIBIT K

## PART 2

### EXPLANATION OF BRACKETS (HMO PLAN)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contract Holder], and [ABC].
b. Some areas of variability are noted with brief explanations within the text.
c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract forms.

1. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
2. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements.
3. The Generic Drug definition can be deleted if not needed.
4. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
5. OB/GYNs can be considered Primary Care Physicians.
6. Eligible class references can be removed.
7. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Carrier. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.
8. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.
9. Small Claims Waiver can be deleted.
10. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy—Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
11. Transfer of Primary Care Physician can occur according to carrier administration.

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Carrier:
Group Medical Claims
PO Box XXXXX
Anywhere, New Jersey XXXXX

EXHIBIT M

GE 0094

# Annual Family Profile and Claim Notice

Send this form once each calendar year to the address above with your first claim of the year. If any information changes, send a new one. If you have questions about claims or need forms, call XXX-XXX-XXXX

| Employer name | Employer phone number | Plan/Policy Number |
|---|---|---|
| | | |

Check one ☐ Active employee ☐ Retired employee ☐ Continued individual

## Employee information

| Name | Date of birth | Social Security Number |
|---|---|---|
| | | |

| Address | City | State | ZIP | Home phone number |
|---|---|---|---|---|
| | | | | |

| Do you have another employer? ☐Yes ☐No | If "Yes," please give name of other employer | Other employer's phone number |
|---|---|---|
| | | |

| Are you covered by another group plan? ☐Yes ☐No | If "Yes," please give name of carrier | Plan number | Other carrier's phone number |
|---|---|---|---|
| | | | |

## Spouse information

| Name | Date of birth | Social Security Number |
|---|---|---|
| | | |

| Name and address of spouse's employer | Phone number of spouse's employer |
|---|---|
| | |

| Is spouse covered by another group plan? ☐Yes ☐No | If "Yes," please give name of other carrier | Plan number | Other carrier's phone number |
|---|---|---|---|
| | | | |

## Dependent children information

| Name | Date of birth ☐Male ☐Female | Social Security No. | Relation to employee | Handicapped ☐Yes ☐No |
|---|---|---|---|---|
| Name | Date of birth ☐Male ☐Female | Social Security No. | Relation to employee | Handicapped ☐Yes ☐No |
| Name | Date of birth ☐Male ☐Female | Social Security No. | Relation to employee | Handicapped ☐Yes ☐No |
| Name | Date of birth ☐Male ☐Female | Social Security No. | Relation to employee | Handicapped ☐Yes ☐No |

List any additional dependent children on a separate page and attach it to this form.
If any child is over the limiting age and a full-time student, please give the information requested below.

| Name | Name of school | Address of school |
|---|---|---|
| Name | Name of school | Address of school |

If any child is covered by another group plan, please give the information requested below.

| Name | Insured person | Name of carrier | Plan number |
|---|---|---|---|
| Name | Insured person | Name of carrier | Plan number |

I authorize any provider, insurer, or other organization to release any information regarding the medical history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a criminal act.

Signature of employee _____ Signature of patient if other than minor child _____ Date _____

SEH-FP-7/93

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## EXHIBIT L

## PART 1

## PATIENT INSTRUCTIONS

## FOR HCFA 1500

To request reimbursement for medical expenses; please complete the attached form blocks 1 through 13. To assist you, follow the instructions below. Please remember that all statements must be accurate.

Please bring this claim form with you at the time the medical services are rendered. The provider of service is responsible for completing blocks 14 through 33.

When requesting reimbursement, you should also attach copies of itemized bills and receipts for the medical services for which you are submitting a claim.

### PATIENT INSTRUCTIONS

**Block 1**

Place an "X" in the appropriate block which identifies the type of insurance program that applies to the claim.

**Block 1a**

Enter the Social Security number or unique identification number assigned by the insurance carrier or the individual in whose name the insurance is carried.

**Block 2**

Enter the patient's last name, first name and middle initial.

**Block 3**

Enter the patient's date of birth in a MMDDYY format. Example: 01 12 94 for January 12, 1994. Place an "X" in the appropriate gender box.

**Block 4**

Enter the last name, first name and middle initial of the individual in whose name the insurance is carried.

**Block 5**

Enter the mailing address of the patient.

**Block 6**

Place an "X" in the appropriate box which identifies the relationship of the patient to the insured individual.

**Block 7**

Enter the mailing address of the individual who holds the insurance if it is different from the patient's address listed in Block 5. Otherwise, enter the word "SAME".

**Block 8**

Place an "X" in the appropriate box which identifies the patient's marital status. Also, place an "X" in the appropriate box which identifies the employment/student status of the patient.

**Block 9**

If the patient has other insurance, enter the last name, first name and middle initial of the covered individual if it is different from that shown in Block 4. Otherwise, enter the word SAME.

**Block 9a**

Enter the other insurance carrier's identification number or unique code assigned by the carrier to identify the group or policy under which the individual in Block 9 is covered.

**Block 9b**

Enter the date of birth or the individual (listed in Block 9) in a MMDDYY format. Example: 011294 for January 12, 1994.

Enter an "X" in the appropriate gender box.

**Block 9c**

Enter the name of the individual's (listed in Block 9) employer or school name.

**Block 9d**

Enter the name of the insurance program covering the individual in Block 9.

**Block 10a through 10c**

Place an "X" in the appropriate box to indicate whether the patient's condition is related to employment, auto accident, or other accident. For auto accidents, indicate the states abbreviation in which the accident occurred (e.g. New Jersey—NJ).

**Block 10d**

This field is not required.

**Block 11**

Enter the identification or unique code assigned by the carrier to identify the group or policy under which the individual is covered.

**Block 11a**

Enter the individual's (listed in Block 4) birthdate in a MMDDYY format. Example: 011294 represents January 12, 1994.

Place an "X" in the appropriate gender box.

**Block 11b**

Enter the individual's (listed in Block 4) **employer name or school name.**

**Block 11c**

Enter the name of the insurance program covering the individual in Block 4.

**Block 11d**

Place an "X" in the appropriate box. If the answer is YES, complete sections 9a-9d.

**Block 12**

The patient's signature in this field authorizes release of medical information necessary to process this claim. The patient or an authorized representative should sign and date this block unless the signature is on file in the provider's office/facility.

**Block 13**

The signature in this block authorizes the insurance carrier to release insurance benefits directly to the provider of the services listed in Block 33.

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## EXHIBIT L

## PART 2

APPROVED OMB NO 0938-0279

1 | 2 | 3 PATIENT CONTROL NUMBER | 4 TYPE OF BILL

5 BC/BS PROV NO | 6 FEDERAL TAX NO | 7 MEDICARE NO | 8 MEDICAID NO | 9

10 PATIENT'S LAST NAME | FIRST NAME | INITIAL | 11 PATIENT'S ADDRESS | CITY | STATE | ZIP

12 BIRTH DATE | 13 SEX | 14 MS | ADMISSION: 15 DATE | 16 HR | 17 TYPE | 18 SRC | 19 A H | 20 D H | 21 STAT | 22 STATEMENT COVERS PERIOD: FROM | THROUGH | 23 COV D | 24 N C D | 25 C I D | 26 L R D | 27

28 OCCURRENCE: CD | DATE | 29 OCCURRENCE: CD | DATE | 30 OCCURRENCE: CD | DATE | 31 OCCURRENCE: CD | DATE | 32 OCCURRENCE: CD | DATE | 33 OCCURRENCE SPAN: CD | FROM | THROUGH

34 | CONDITION CODES: 35 | 36 | 37 | 38 | 39 | BLOOD RECORD (PINTS): 40 FURN | 41 REPL | 42 NOT RP | 43 DED | 44 SP PROG | 45

46 VALUE: CD | AMT | 47 VALUE: CD | AMT | 48 VALUE: CD | AMT | 49 VALUE: CD | AMT

a
b

50 DESCRIPTION | 51 R CODE | 52 S UNITS | 53 TOTAL CHARGES | 54 | 55 | 56

57 PAYER | 58 REL INFO | 59 ASG BEN | 60 DEDUCTIBLE | 61 CO-INSURANCE | 62 EST RESPONSIBILITY | 63 PRIOR PAYMENTS | 64 EST AMOUNT DUE

A
B
C

DUE FROM PATIENT ▶

65 INSURED'S NAME | 66 SEX | 67 P REL | 68 CERT SSN-HIC ID NO | 69 GROUP NAME | 70 INSURANCE GROUP NO

A
B
C

71 EID | 72 ESC | 73 EMPLOYER NAME | 74 EMPLOYEE ID | 75 EMPLOYER LOCATION

**NOTICE TO THE PATIENT**

The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

UB-82 HCFA-1450

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PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

☐☐☐ PICA

# HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __ 3. ___ . __

2. ___ . __ 4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

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**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

**REFERS TO GOVERNMENT PROGRAMS ONLY**

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION**

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS:** PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

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# LABOR

## (a)

## DIVISION OF ADMINISTRATION

### Rulemaking
### Petitions for Rules
### Proposed Readoption: N.J.A.C. 12:6

Authorized By: Raymond L. Bramucci, Commissioner, Department of Labor.

Authority: N.J.S.A. 34:1-20, 34:1A-3(e) and 52:14B-4(f), and N.J.A.C. 1:30-3.6.

Proposal Number: PRN 1993-457.

Submit written comments by September 15, 1993 to:
Linda Flores, Esquire
Special Assistant for External and Regulatory Affairs
Office of the Commissioner
Department of Labor
CN 110
Trenton, New Jersey 08625-0110

The agency proposal follows:

**Summary**

Pursuant to Executive Order No. 66(1978), N.J.A.C. 12:6, Rulemaking, is scheduled to expire on October 17, 1993. These rules set forth the procedure and form for petitioning the Department of Labor to promulgate, amend or repeal a rule, including the substantive content of petitions and timeframes for the disposition of petitions by the Department. The Department has reviewed these rules and determined them to be necessary, reasonable, adequate, efficient, understandable and responsive to the purpose for which they were originally promulgated. Accordingly, the Department is proposing these rules for readoption.

Pursuant to N.J.S.A. 52:14B-4(f), any interested person may petition an agency to initiate rulemaking action. N.J.S.A. 52:14B-4(f) also requires an agency to prescribe the form for the petition and the procedure for the submission, consideration and disposition of the petition.

To implement the statutory mandate found at N.J.S.A. 52:14B-4(f), the rules proposed for readoption set forth the form for petitioning the Department of Labor (Department) to promulgate, amend or repeal a rule as well as the procedures, including timeframes, governing the Department's disposition of petitions for rulemaking.

N.J.A.C. 12:6-1.1 sets forth the scope of the rules.

N.J.A.C. 12:6-1.2 describes the procedure to be followed by any person interested in petitioning the Department to initiate rulemaking action. A petition for rulemaking must be in writing and contain the name of the petitioner; the substance or nature of the rulemaking which is requested; the reasons for the request and the petitioner's interest in the request; and references to the authority of the Department to take action.

N.J.A.C. 12:6-1.3 sets forth the procedures governing the Department. Upon receipt of the petition, the Department must file a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. Within 30 days of receiving the petition, the Department must mail to the petitioner and file with the Office of Administrative Law a notice of action on the petition that will also be published in the New Jersey Register. Finally, the Department must act on a petition by denying it, filing a notice of proposal or notice of pre-proposal, or referring the matter for further deliberation. In the event the matter requires further consideration, the final disposition of the petition is mailed to the petitioner and published in the New Jersey Register.

The rules governing the petitions for rulemaking provide clear guidance to any person interested in initiating rulemaking and to the Department in responding to petitions. Because the Department believes the current text of the subchapter is sufficient for the purposes of administering petitions for rulemaking, the rules are being proposed for readoption without amendment.

**Social Impact**

The public will benefit from the readoption because it will be informed on the procedure necessary to initiate agency rulemaking action. The rules provide a mechanism for the public to be heard on any matter of interest and to compel agency review and consideration of its request.

The Department will benefit from the readoption since the rules set forth a formalized procedure for handling requests for rulemaking and ensure timely disposition of rulemaking petitions.

**Economic Impact**

Readoption will have no direct impact on the public or the Department. The Department routinely handles, as part of its general rulemaking responsibilities, comments and suggestions made by the public regarding specific rules. Moreover, the number of rulemaking petitions submitted to the Department have been minimal, thus permitting the Department to respond with existing staff resources.

**Regulatory Flexibility Statement**

Readoption will have no direct impact on small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules do not impose any reporting, recordkeeping or other requirements. Readoption would provide small businesses interested in having the Department initiate rulemaking action with a streamlined process for having their concerns heard and acted upon in a timely fashion.

**Full text** of the proposed readoption can be found in the New Jersey Administrative Code at N.J.A.C. 12:6.

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# PUBLIC UTILITIES

## (b)

## BOARD OF REGULATORY COMMISSIONERS

### Notice of Pre-Proposal
### IntraLATA Competition for Telecommunications Services

Authorized By: Board of Regulatory Commissioners, Dr. Edward H. Salmon, Chairman, Jeremiah F. O'Connor, Commissioner, and Carmen J. Armenti, Commissioner.

Authority: N.J.S.A. 48:2-13 and 48:2-21.20.

BRC Docket Number: TX93060259.

Pre-Proposal Number: PPR 1993-4.

Submit written comments by September 15, 1993 to:
Michael P. Gallagher, Director
Division of Telecommunications
Board of Regulatory Commissioners
Two Gateway Center
Newark, New Jersey 07102

Submit reply comments by October 1, 1993 to the above address.

**Take notice** that the Board of Regulatory Commissioners (Board) is interested in receiving comments for establishing rules regarding the possibility of permitting some form of competition for the provision of telecommunications services within a LATA (Local Access Transport Area). Pursuant to the Modification of Final Judgment, *U.S. v. American Tel. Co.*, 552 *F.Supp.* 131 (D.D.C. 1982), *aff'd sub nom Maryland v. U.S.*, 460 *U.S.* 1001 (1983), interexchange carriers (IXCs) are permitted to provide service between LATAs, while local exchange carriers (LECs) are prohibited from doing so. Pursuant to the policies established by the Board since the divestiture of AT&T, and the Bell system, the Board had determined that it was appropriate for only LECs to provide service within a LATA. There are three LATAs in New Jersey. Originally the Board required all calls attempted within a LATA by a carrier other than the LEC to be blocked; however, over time the Board permitted compensation to be paid to the LEC for completed intraLATA traffic as an alternative to blocking. Pursuant to the Telecommunications Act of 1992, the Board has the authority to determine the terms and conditions of interLATA service (N.J.S.A. 48:2-21.20).

The Board established its intraLATA competition policy at divestiture in light of concerns on the impact of the loss of intraLATA telephone traffic revenues on a LEC's ability to provide universal service at affordable basic rates. It was at that time, and remains, a primary concern of the Board that all New Jersey residents have access to affordable telephone service. Any change in policy should not have adverse consequences on the goal of universal service.

Several IXCs have requested that the Board revise its policies and permit competition for intraLATA services and to remove the require-

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ment of payment of compensation for intraLATA traffic. Further, in the case of *In re Petition of MCI Telecommunications Corp.,* 263 *N.J. Super.* 313 (App. Div. 1993), the Appellate Division determined that the Board should afford MCI an opportunity to be heard on its request to examine Board policies. Sprint Communications Corp., Docket No. TE92111047, and AT&T Communications of New Jersey, Inc., Docket No. TE93060211, have filed specific petitions requesting that the Board modify its intraLATA competition policy.

After evaluating the requests of these IXCs, the Board believes that, initially, it is appropriate to seek comment from interested parties in a rulemaking-type proceeding. See *Metromedia, Inc. v. Director, Division of Taxation,* 97 *N.J.* 313 (1984). The Board believes that any policy set in this area will have wide impact on the regulated community and the public in general. Therefore, it is appropriate to seek input from the widest range of interested parties as possible. However, based on information now available to the Board, it does not believe it is appropriate to promulgate the text of a rulemaking at this time.

The Board seeks comment from interested parties on whether intraLATA competition, and compensation, should be retained in the existing form, modified, or changed. In other words, should intraLATA competition be permitted, or not? If intraLATA competition is permitted, what is the proper form and extent of such competition? The Board has developed a series of questions that it believes must be, or should be, explored prior to making a decision. The Board seeks specific factual information on these points rather than broad generalization or policy statements. Based on the review of the comments received in this proceeding, the Board may refer certain issues to the Office of Administrative Law for further factual determination in specific areas. If such an approach is undertaken, the Board anticipates streamlined proceedings on limited factual issues. Therefore, in order to assist its review, the Board believes it is important that commenters supply detailed supporting information in responding to these issues.

Additionally, commenters are encouraged to supply proposed text of rules which the Board may consider for promulgation. Any such text should adequately address the impact on all affected parties and should also include procedures.

In light of the complexity of the issues, the Board will permit the filing of reply comments. Reply comments are comments offered in response to the written comments filed with the BRC pursuant to this rulemaking. However, the Board believes that it is important to expedite this process as much as possible. Therefore, parties should not anticipate that the comment deadlines will be extended. Copies of all comments are available for inspection at the Board's offices in both Newark and Trenton.

Commenters are asked to respond to any and all of the following:

(1) What is the impact and implications of intraLATA competition on universal service?

(2) What is the impact and implication of intraLATA competition on LEC basic exchange rates?

(3) What is the anticipated impact of intraLATA competition on a typical customer bill, including all element charges (for example, basic, toll, custom calling services) for low use, medium use and high use customers?

(4) What services are anticipated to be included as part of intraLATA competition (for example, toll, local, custom calling services)? Will IXC's offer optional services such as custom calling-type services?

(5) What benefits/detriments are expected to be realized by consumers if intraLATA competition is allowed? (for example, what rates will be impacted and how? What services? What billing arrangements?)

(6) Does basic telephone service need to be redefined? (that is, What elements should be included under the definition of basic service?)

(7) Under the Telecommunication Act of 1992, toll is a protected service. Should toll be considered a competitive service if intraLATA competition is permitted?

(8) Should tariffs be filed by common carriers and/or any other intraLATA provider of telecommunications service, and, if so, under what requirements?

(9) What network provisioning is necessary to implement carrier of choice on an equal access basis? What are the technical implications and limitations of "1+ dialing" so that end users can choose a carrier other than her or his current local exchange carrier?

(10) Should end users have the choice of more than one carrier under an equal access format (for example, dual presubscription)?

(11) Will the introduction of intraLATA competition result in geographic rate deaveraging? Will there be a need for rate deaveraging?

(12) The FCC requires a subscriber line charge (SLC). Should there be a separate intraLATA subscriber line charge to implement competition? If not, why? If yes, why?

(13) Is it appropriate to limit competition to certain lines of business (for example, WATS, 800)? If yes, what are the anticipated impacts on carriers and end users?

(14) Should an intraLATA access charge be implemented, and if so, at what level (for example, the same as the current intraLATA access charge)?

(15) If a switched network is utilized in competition with the LEC network, should it be mandated that access be on a common carrier basis? If so, under what terms and conditions? If not, why?

(16) Should imputation be considered for all carriers, and how should it be applied?

(17) If intraLATA competition is implemented, should compensation end immediately, be phased-out, or continued?

(18) Should competition be phased-in for all services or some services, and if some services, which ones and over what time frame?

(19) Is balloting appropriate for the selection of a carrier and if so, what procedure should be considered? For example, should customers remain with their current carrier if no selection is made?

(20) Is it appropriate for customers to pay an intrastate SLC if they select a carrier other than their current LEC for intraLATA service? What is the appropriate disposition of this revenue?

(21) If dual presubscription is permitted, who should be responsible for the network costs incurred to provide the technical means to offer this presubscription format?

(22) What revenue losses, by specific service categories, would be experienced by local exchange carriers as a result of competition on a presubscription basis? On an access code basis?

(23) Should revenue losses experienced by local exchange carriers resulting from presubscription based competition be recovered in some other fashion? From access code based competition? If yes, what rates should be increased and how much?

(24) How do New Jersey's intraLATA toll rates compare with the other jurisdictions which have allowed intraLATA toll competition?

(25) How do New Jersey's basic exchange rates compare with other jurisdictions which have allowed intraLATA toll competition?

(26) What would be the impact upon basic exchange rates and universal service if competition on an access code basis was adopted as Board policy? On a presubscription basis?

(27) Any relevant issues not previously discussed.

# TRANSPORTATION

## (a)

### DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

### BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

### Mid-Block Crosswalk
### Route N.J. 71 in Monmouth County
### Proposed New Rule: N.J.A.C. 16:30-10.16

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-34.

Proposal Number: PRN 1993-451.

Submit comments by September 15, 1993 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

The proposed new rule will establish a "mid-block crosswalk" along Route N.J. 71 in the Borough of Belmar, Monmouth County, to enhance

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pedestrian safety and traffic flow. This mid-block crosswalk will provide a designated area for persons to legally cross the roadway at other than an area which is controlled and directed by a police officer or a traffic control device.

As part of a review of current conditions, and upon request from the local government, the Department's Bureau of Traffic Engineering and Safety Programs conducted a traffic investigation. The investigation proved that the establishment of a "mid-block crosswalk" along Route N.J. 71 in the Borough of Belmar, Monmouth County, was warranted.

The Department, therefore, proposes new rule N.J.A.C. 16:30-10.16 to establish this mid-block crosswalk.

**Social Impact**

The proposed new rule will establish a "mid-block crosswalk" along Route N.J. 71 in the Borough of Belmar, Monmouth County, to provide a designated area for persons to legally cross the roadway at other than an area which is controlled and directed by a police officer or a traffic control device. Appropriate signs will be erected to advise the motoring public and ensure pedestrian safety.

**Economic Impact**

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of "mid-block crosswalk" zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

**Regulatory Flexibility Statement**

The proposed new rule does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed new rule primarily affects the motoring public, pedestrians, and the governmental entities responsible for the enforcement of the rule.

**Full text** of the proposed new rule follows:

16:30-10.16 Route 71

(a) The certain parts of State highway Route 71 described in this subsection shall be designated as a mid-block crosswalk:

1. In Monmouth County:

i. Borough of Belmar:

(1) From a point 200 feet west of the westerly curb line of Belmar Plaza to a point six feet westerly therefrom.

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# (a)

## DIVISION OF TRANSPORTATION ASSISTANCE OFFICE OF REGULATORY AFFAIRS

## Zone of Rate Freedom

## Proposed Amendment: N.J.A.C. 16:53D-1.1

Authorized By: William D. Ankner, Director, Division of Policy and Capital Programming.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 48:2-21 and 48:4-2.20 through 2.25.

Proposal Number: PRN 1993-443.

A **public hearing** concerning this proposal will be held on:
Thursday, September 2, 1993, at 1:00 P.M. to 3:00 P.M.
Multi-Purpose Room
New Jersey Department of Transportation
1035 Parkway Avenue
Trenton, New Jersey 08625

Submit written comments by September 15, 1993 to:
Charles L. Meyers
Administrative Practice Officer
Department of Transportation
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625
(609) 530-5720

The agency proposal follows:

**Summary**

The proposed amendment implements certain provisions of N.J.S.A. 48:2 which directs the Commissioner of the Department of Transportation to establish a Zone of Rate Freedom (ZORF) for the regular route private autobus carriers operating within the State. The ZORF constitutes a limited percentage range to be set annually by the Commissioner in which regular route private autobus carriers may be permitted to adjust their rates, fares or charges without petitioning the Department for prior approval. Provided the autobus carrier remains within the designated percentage range, all that is required is notice to the Department and the riding public of the rate, fare or charge adjustment prior to the effective date. If, however, the regular route autobus carrier seeks a percentage adjustment greater than that provided for in the ZORF, such autobus carrier will be required to follow the standard petitioning procedures, as specified in N.J.S.A. 48:2-21 and N.J.A.C. 16:51-3.10 and 3.11.

After extensive review of the ZORF and its relationship to regular route private autobus carrier costs, revenues and fare structures, the Department proposes to amend the current ZORF. The percentage limitations contained in the 1994 proposal are scaled in consideration of the varying fares currently charged by intrastate regular route private autobus operations.

The percentages set forth in the 1994 proposal do not apply to casino or regular route in the nature of special, charter and special autobus service operating within the State. Pursuant to N.J.S.A. 48:4-2.25, the Commissioner is authorized to exempt casino or regular route in the nature of special, charter and special autobus operations from the purview of the rate regulation. In accordance with said authority, the Commissioner continues to so exempt casino or regular route in the nature of special, charter and special autobus operations within the State during the calendar year of 1994, subject to the existing conditions regarding notices to the public and filings with the Department.

**Social Impact**

The proposed 1994 ZORF Percentage amendment will enable private autobus carriers, in most cases, to modify regular route fares as may be required without incurring administrative hearing costs, while also limiting the chance for uncontestable fare increases to adversely impact on the public. In the Department's opinion, the fare changes permitted by the proposed 1994 ZORF will not be burdensome to the public or regular route private autobus companies.

**Economic Impact**

The proposed 1994 Percentage amendment will afford privately owned autobus companies flexibility in regular route fare adjustment. Such carriers will not have to incur costly and time consuming petition procedures when their proposed fare adjustments are consistent with that allowed.

**Regulatory Flexibility Statement**

A number of the autobus carriers affected by the proposed amendment are small businesses, as that term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment does not place any new reporting or recordkeeping requirements on such autobus carriers. First time autobus carriers commencing operations will have to meet the reporting and recordkeeping requirements otherwise established by law for autobus carriers. The proposed amendment sets raised limits on rate modifications for which compliance with N.J.A.C. 16:53D-3.10 and 3.11 is not required.

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

16:53D-1.1 General provisions

(a) Any regular route autobus carrier operating within the State which seeks to revise its rates, fares or charges in effect as of the time of the promulgation of this rule shall not be required to conform with N.J.A.C. 16:51-3.10 (Tariff filings or petitions which do not propose increases in charges to [consumers] **customers**) or N.J.A.C. 16:51-3.11 (Tariff filings or petitions which propose increases in charges to customers) provided the increase or decrease in the rate, fare or charge, or the aggregate of increases and decreases in any single rate, fare or charge is not more than the maximum percentage increase or decrease as promulgated below upgraded to the nearest $.05.

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1. The following chart sets forth the [1993] **1994** percentage maximum for increases to particular rates, fares or charges and the resultant amount as upgraded to the nearest $.05:

| Present Fare | % Of Increase | Increase Upgraded To Nearest $.05 |
|---|---|---|
| $1.10 or less | [4.5%] **4.0%** | $.05 |
| $1.15-$2.20 | [4.5%] **4.0%** | $.10 |
| $2.25-$3.30 | [4.5%] **4.0%** | $.15 |
| $3.35 upward | [4.5%] **4.0%** | $.20+ |

2. The following chart sets forth the [1993] **1994** percentage maximum for decrease to particular rates, fares or charges and the resultant amount as upgraded to the nearest $.05:

| Present Fare | % Of Decrease | Decrease Upgraded To Nearest $.05 |
|---|---|---|
| $ .50 or less | 10% | $.05 |
| $ .55-$1.00 | 10% | $.10 |
| $1.05 upward | 10% | $.15+ |

# OTHER AGENCIES

## (a)

### NEW JERSEY TURNPIKE AUTHORITY

### Notice of Extension of Comment Period
### New Jersey Turnpike Authority Rules
### Proposed Readoption with Amendments: N.J.A.C. 19:9

**Take notice** that the New Jersey Turnpike Authority is extending the public comment period for the proposed readoption with amendments of the Authority's rules at N.J.A.C. 19:9, published in the July 6, 1993 New Jersey Register at 25 N.J.R. 2839(b), to August 26, 1993.

Submit comments by August 26, 1993 to:
Herbert I. Olarsch, Esq.
Secretary and Director of Law
New Jersey Turnpike Authority
P.O. Box 1121
New Brunswick, New Jersey 08903

## (b)

### CASINO CONTROL COMMISSION

### Applications
### Hearings
### Reapplication by Natural Person After Denial or Revocation
### Motions for Reconsideration; Motions for Relief
### Proposed Amendment: N.J.A.C. 19:41-8.8
### Proposed New Rule: N.J.A.C. 19:42-2.2

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.
Authority: N.J.S.A. 5:12-63c, 69a, 70a, 70d, 94 and 107d.
Proposal Number: PRN 1993-436.

Submit written comments by September 15, 1993 to:
Antonia Z. Cowan, Senior Counsel
Casino Control Commission
Tennessee Avenue and Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

**Summary**

Casino Control Commission ("Commission") regulations provide that an individual whose license, registration or approval is revoked or denied by the Commission may not reapply for a period of five years. N.J.A.C. 19:41-8.8(a). A 10-year restriction applies after the denial or revocation of a casino key license based upon conviction of a statutorily disqualifying offense pursuant to N.J.S.A. 5:12-86c, or acts constituting such an offense pursuant to N.J.S.A. 5:12-86g. N.J.A.C. 19:41-8.8(a)1 and (a)2. The proposed amendments establish the time period for disqualification and clarify the standards, procedures and time limitations on reapplication and early reapplication by such persons.

Proposed amendments to N.J.A.C. 19:41-8.8(a) recognize that the Commission may approve a settlement of a contested case which permits reapplication after a period of less than five years. However, the proposed rule would prohibit a party to such a settlement from petitioning for early reapplication pursuant to N.J.A.C. 19:41-8.8(d).

The proposal would also eliminate the portion of paragraph N.J.A.C. 19:41-8.8(b)5 which presently provides that, where conviction of a statutorily disqualifying offense is the basis for denial or revocation, reapplication is permitted upon issuance of a judicial order for expungement or sealing. The amended rule would eliminate this basis for allowing reapplication. In employee licensing matters, while a criminal record concerning a disqualifying offense may be expunged or sealed, the Commission is not precluded from inquiry by means of other evidence into an individual's conduct, in accordance with N.J.S.A. 5:12-86g. The proposed elimination of expungement as a basis for reapplication is consistent with this approach.

The proposal also amends the rules regarding petitions for early reapplication, at proposed N.J.A.C. 19:41-8.8(d). The amended rule would permit the filing of a petition for early reapplication at any time after one year has elapsed since the date of the denial or revocation, or at such earlier date specified by the Commission at the time of the denial or revocation. The amendments, in order to conform with Commission practice, eliminate the requirement that the petitions be verified and supported by affidavits and simplify the petitioner's burden by requiring only certification by the petitioner that the statements contained in the petition are true. Only one such petition may be filed for each license, registration, qualification or approval denied or revoked by the Commission in any five year disqualification period.

The proposed amendments also modify the standard for Commission review of petitions for early reapplication. The current standard of "extraordinary facts and circumstances" is eliminated. Under the proposal, the Commission would instead consider whether the facts and circumstances would be reasonably likely to result in licensure, registration, qualification or approval when presented at a plenary hearing. Proposed factors that may be considered by the Commission in determining a petition for early reapplication would include, when appropriate, evidence in support of a finding of rehabilitation pursuant to sections 90h and 91d of the Casino Control Act ("the Act"), or in support of a finding of waiver of any disqualification pursuant to section 91e of the Act. The proposed amendments clarify that the focus for a motion for early reapplication is on facts and circumstances subsequent to a denial or revocation. In contrast, a motion pursuant to section 107d of the Act seeks to set aside a Commission order by reexamining the grounds for the previous judgment.

N.J.A.C. 19:41-8.8(b) is also amended to delete references to section 91b of the Act (hotel registration), since the financial stability and residency requirements in the Act no longer apply to applicants for hotel employee registration. Other proposed amendments to N.J.A.C. 19:4-8.8 recodify various provisions in subsections (b) through (f) as a means of simplifying and clarifying the rule.

Proposed new rule N.J.A.C. 19:42-2.2 addresses motions for reconsideration of or relief from a final Commission order, pursuant to N.J.S.A. 5:12-107d. In accordance with section 107d(1) of the Act, the proposed rule provides that a party may, within 10 days after service of a final Commission order, file a motion for reconsideration. Such motion, which does not necessarily seek to reopen the record, may be granted by the Commission if it finds cause based upon legal, policy or factual argument advanced by the moving party or raised on its own motion. N.J.S.A. 5:12-107d(1).

In accordance with section 107d(2) of the Act, the proposed rule provides that a party to a contested case may, within one year from service of a final order, file a motion to reopen the record based upon newly discovered evidence. Such motion must establish sufficient reason for the failure to present such evidence at the hearing or on a motion for reconsideration pursuant to N.J.S.A. 5:12-107d(1). The Commission may grant such motion upon a showing that the newly discovered evidence is material and necessary and reasonably likely to change the

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final decision and that sufficient reason existed for failure to present such evidence at the original hearing or on a motion for reconsideration pursuant to N.J.A.C. 19:42-2.2(a).

Similarly, in accordance with section 107d(3) of the Act, the proposed rule provides that a party may file a motion for relief from a final Commission order and request that the order be vacated or modified, or that the record be reopened, or that a hearing be granted pursuant to section 107d, based upon mistake, inadvertence, surprise or excusable neglect; fraud, misrepresentation or other misconduct of an adverse party; or "any other reason consistent with the public policy of the Act and in the interests of justice." Such motion must be filed within one year from service of the final order. The proposed new rule also emphasizes that neither the filing of such motion, nor a Commission order granting such motion, will suspend the operation of any order unless otherwise expressly specified by order of the Commission. This proposed new rule is consistent with the standards for a motion for relief pursuant to the New Jersey Court Rules, R.4:50-1, 4:50-2 and 4:50-3.

**Social Impact**

N.J.A.C. 19:41-8.8 impacts on the rights of an individual whose casino key employee license, casino employee license or casino hotel employee registration has been revoked or denied. The proposed amendment should benefit these individuals, as well as the regulatory agencies implementing these provisions, by providing more specific procedures and consistent standards for the reapplication process. Likewise, proposed new rule N.J.A.C. 19:42-2.2 should benefit parties in contested cases before the Commission, by articulating consistent standards for motions for reconsideration of or relief from a final Commission decision or order pursuant to N.J.S.A. 5:12-107d(1)-(d)3.

**Economic Impact**

The proposed amendments and new rule can be expected to benefit both the regulatory agencies and prospective petitioners by providing more explicit procedural requirements and substantive standards. Such standards should avoid unnecessary expenditure of time and expense incurred in filing, reviewing and processing petitions which are not timely filed or which do not include appropriate supporting evidence.

**Regulatory Flexibility Statement**

The proposed amendments to N.J.A.C. 19:41-8.8 affect reapplication by natural persons, none of which qualify as a small business under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Proposed new rule N.J.A.C. 19:42-2.2 impacts upon all parties in contested cases before the Commission, including some parties who are casino service industry ("CSI") licensees or applicants. Some of these CSI licensees or applicants may qualify as a "small business" under the standards set forth in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Fair and efficient procedural standards must be applied consistently to all parties to contested cases, including small businesses. However, the new rule simply codifies motion practice in accordance with section 107d of the Act. No new reporting, recordkeeping or other compliance requirements are established, and thus no new costs will be incurred by small businesses as a result of this new rule.

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

19:41-8.8 Reapplication by natural person after denial or revocation

(a) Any natural person [required to be licensed, qualified or approved under the provisions of the Act or regulations of the Commission] whose licensure, **registration,** qualification[,] or approval is [either] denied or revoked by the Commission [on the basis of that person's] **for** failure to satisfy the affirmative qualification criteria of the Act[,] or due to a Commission finding that such person is disqualified [under the criteria of Section] **pursuant to section** 86 of the Act, or both, may not, except as otherwise provided [in (b), (f) and (g) below] **by this section**, reapply for licensure, **registration,** qualification or approval until five years have elapsed from the date of [said] denial or revocation. **Notwithstanding the foregoing:**

**1. If the denial or revocation was based upon conviction of a disqualifying offense pursuant to section 86c of the Act and reapplication is to be evaluated under the standards of section 89 of the Act, reapplication is permitted after the lapse of 10 years from the date of conviction;**

**2. If the denial or revocation was based on acts constituting a section 86c disqualifying offense pursuant to section 86g and reapplication is to be evaluated under the standards of section 89 of the Act, reapplication is permitted after the lapse of 10 years from the date of the conduct in question; and**

**3. If the Commission approves an agreement resolving an application for or a complaint seeking the revocation of licensure, registration, qualification or approval which results in denial or revocation but permits reapplication after a stated period of less than five years, eligibility for reapplication shall be determined as specified in the agreement and not by the provisions of this section.**

(b) Any natural person whose licensure, **registration,** qualification or approval is denied or revoked by the Commission on the basis of any of the [following enumerated provisions of the Act or regulations of the Commission] **statutory or regulatory provisions specified in (b)1 through 6 below** may reapply[, in accordance with the procedure set forth in (c) below,] for licensure, **registration,** qualification or approval upon satisfaction of the [conditions specified herein:] **relevant requirements stated below. If the denial or revocation was based upon two or more statutory or regulatory provisions, the Commission shall permit reapplication only upon compliance with the requirements of this subsection as to each such provision. Any person seeking to reapply pursuant to this subsection shall file a certified petition stating with particularity the satisfaction of the specified requirements.**

1. Lack of financial stability pursuant to [Sections] **sections** [89(b)1,] **89b(1) or** [90(b) or 91(b)] **90b** of the Act: Reapplication is permitted upon said person achieving status of financial stability.

2. Lack of business ability and casino experience pursuant to [Sections] **sections** [89(b)(3)] **89b(3)** or [90(b)] **90b** of the Act: Reapplication is permitted upon said person acquiring the requisite business ability and casino experience.

3. Failure to satisfy residency requirement pursuant to [Sections] **sections** [89(b)(4)] **89b(4)** or [90(b)] **90b** [and 91(b)] of the Act[, and/or N.J.A.C. 19:41-4.3]: Reapplication is permitted upon said person actually establishing residency as required, or upon a Commission finding [of sufficient intent to establish such residency.] **that such residency will be obtained prior to the completion of the processing of said reapplication, or upon a Commission finding that the residency requirements should be waived pursuant to sections 89b(4) or 90c of the Act.**

4. (No change.)

[5. Conviction of statutory disqualifier pursuant to Section 86c of the Act: If reapplication is to be evaluated under the standards of Sections 90 or 91 of the Act, reapplication is permitted after the lapse of five years from the date of denial or revocation, or upon the issuance of a judicial order of expungement or sealing, whichever occurs first. If reapplication is to be evaluated under the standards of Section 89 of the Act, reapplication is permitted after the lapse of 10 years from the date of conviction or upon the issuance of a judicial order of expungement or sealing, whichever occurs first.]

[6.]**5.** [Prosecution or pending] **Pending** charges [related to statutory disqualifier] **for a section 86c disqualifying offense** pursuant to [Section] **section** [86(d)] **86d** of the Act: Reapplication is permitted upon the disposition of [the prosecution or] pending charges [against said person].

[7. Acts constituting a Section 86c offense pursuant to Section 86(g) of the Act: If reapplication is to be evaluated under the standards of Section 90 or 91 of the Act, reapplication is governed by the provisions of (a) above. If reapplication is to be evaluated under the standards of Section 89 of the Act, reapplication is permitted after the lapse of 10 years from the date of the conduct in question.]

**6. Any statutory or regulatory provision which is subsequently repealed or modified: Reapplication is permitted upon a showing that the subsequent repeal or modification of the statutory or regulatory provision obviates the grounds for denial or revocation and justifies the conclusion that the prior decision should no longer bar reapplication.**

[(c) Any natural person whose licensure, qualification or approval has been denied or revoked on the basis of one or more of the

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enumerated statutory and regulatory provisions set forth in (b) above may reapply for such licensure, qualification or approval as follows:

1. Prior to reapplication, said person shall submit a verified petition, with supporting affidavits requesting that such reapplication be permitted, and showing with particularity the satisfaction of the condition precedent to reapplication specified in (b) above.

2. The Commission may deny the petition or grant the petition and issue an order authorizing reapplication.

3. The Commission shall grant the petition only upon a showing that the condition precedent specified in (b) above has been satisfied in accordance with the provisions of this regulation.

(d) If the licensure, qualification or approval of any natural person has been denied or revoked on the basis of two or more statutory or regulatory provisions, reapplication shall only be permitted upon compliance with the requirements of this regulation as to each statutory or regulatory provision which the Commission found to be a basis for such denial or revocation.]

[(e)]**(c)** This regulation applies with equal force and effect to the denial or revocation of any application by a natural person for licensure, **registration,** [qualifications] **qualification** or approval, and to any denial or revocation of any reapplication for licensure, **registration,** qualification or approval [permitted under the provisions of this regulation] **which was filed after compliance with this section**.

[(f) Any person whose licensure, qualification or approval has been denied or revoked on the basis of any statutory or regulatory provision which has been subsequently repealed or modified in such a manner so as to obviate the grounds for such denial or revocation may petition the Commission, in accordance with the procedures set forth in (c) above, to be permitted to reapply. The petition shall specify with particularity the repeal or modification of the statutory or regulatory provision at issue and the circumstances of the prior denial or revocation which warrant the allowance of such reapplication. The Commission shall grant the petition only upon a showing that the repeal or modification of the statutory or regulatory provision which was the basis of such denial or revocation justifies the conclusion that the prior decision should be modified.]

[(g)]**(d)** Any natural person [whose licensure, qualification or approval has been denied or revoked and] who is barred from reapplication for five years by (a)[, (b)5 or (b)7] above may [petition the Commission to permit early reapplication at any time] **request permission to reapply at an earlier date by filing a petition in accordance with this subsection.**

**1. A petition for early reapplication may be filed at any time after one year has elapsed since the date of denial or revocation or at such earlier date as the Commission may specify in its order; provided, however, that no person shall, within the five-year period of restriction, file more than one such petition for each type of license, registration, qualification or approval authorized by the Act or regulations.**

**2.** [The] **Such** petition shall be [verified and supported by affidavits] **certified** and shall include written argument for the relief sought. [It] **The petition** shall state with particularity [any] **the** grounds upon which denial or revocation was based, and [the] **significant** facts and circumstances **arising since the denial or revocation** which warrant early reapplication.

**3.** Upon receipt of such petition, the Commission shall offer the Division an opportunity to state its position in writing. Based upon the petition and any written submission from the Division, the Commission may deny the petition or, if it finds that [there exist extraordinary] **the** facts and circumstances [warranting early reapplication, grant the petition] **presented are reasonably likely to result in licensure, registration, qualification or approval if considered in a plenary hearing, grant the petition. Factors that may be considered by the Commission may include, where appropriate, evidence which would support:**

**i. A finding of rehabilitation pursuant to sections 90h and 91d; or**

**ii. A waiver of disqualification pursuant to section 91e of the Act.**

**19:42-2.2 Motions for reconsideration; motions to reopen the record; motions for relief**

**(a) Any party may, within 10 days after the service of a final Commission order, file a motion for reconsideration which motion may seek to reopen the record. The motion shall be in writing and shall state the grounds upon which relief is sought. The Commission may grant such motion, under such terms and conditions as the Commission may deem appropriate, when the Commission finds just cause for reconsideration of the order based upon legal, policy or factual argument advanced by the movant or raised by the Commission on its own motion.**

**(b) Any party may, within one year after the service of a final Commission order, file a motion to reopen the record based upon newly discovered evidence. The motion shall be supported by an affidavit of the moving party or counsel showing with particularity the materiality and necessity of the additional evidence and the reason why such evidence was not presented at the original hearing or on a motion for reconsideration pursuant to (a) above. The Commission may grant such motion upon a showing that the newly discovered evidence is material and necessary, that sufficient reason existed for failure to present such evidence and that the evidence is reasonably likely to change the final decision of the Commission. Upon reconsideration, the Commission may modify its decision and order as the additional evidence may warrant.**

**(c) Any party may, within one year of the service of a final Commission order, file a motion for relief from such an order. The motion shall be in writing and shall state the grounds upon which relief is sought. The Commission may grant such motion and vacate or modify the order, reopen the record, or grant a hearing pursuant to N.J.S.A. 5:12-107, upon a showing of the following:**

**1. Mistake, inadvertence, surprise or excusable neglect;**

**2. Fraud, misrepresentation or other misconduct of an adverse party; or**

**3. Any other reason consistent with the public policy of the Act and in the interests of justice.**

**(d) No motion filed pursuant to this section, and no order granting such motion, shall suspend the operation of any final Commission order unless otherwise specified by order of the Commission.**

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# (a)

## CASINO CONTROL COMMISSION

## Casino Hotel Alcoholic Beverage Control
## Classification of Authorized Locations
## Standards for Qualification

## Proposed Amendments: N.J.A.C. 19:50-1.4 and 1.5

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(q) and 103.

Proposal Number: PRN 1993-438.

Submit written comments by September 15, 1993 to:
Seth H. Briliant, Assistant Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

**Summary**

This proposal includes three technical amendments to the Casino Control Commission's casino hotel alcoholic beverage (CHAB) rules.

The first amendment would delete the latter portion of N.J.A.C. 19:50-1.4(d). This subsection was added in connection with the 1991 readoption of the CHAB rules; it codified the common Commission practice of issuing multiple CHAB authorizations for the same CHAB location, so that the area could be used for different purposes at different times without additional Commission authorization.

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The rule also prohibited multiple CHAB authorizations which utilized as one component a Type I (casino), Type III (package goods), or a Type VI (simulcasting) location. The primary purpose of this exception was to prohibit CHAB authorizations which combined complimentary and paid liquor service, such as a "Type I/II (casino/hotel lounge)" authorization. In such an arrangement, it may be possible for cocktail servers to steal drinks and drink receipts by selling free drinks, and it may also be difficult to account for inventory and drink receipts.

However, the Commission no longer requires CHAB licensees to submit or to use internal controls for CHAB locations. Whether a CHAB licensee would wish to create such an arrangement is now a matter best left to the business discretion of the licensee.

Of course, there may still be certain combinations of CHAB authorizations which the Commission, in its discretion, may not wish to issue, such as a Type V/VI (casino simulcasting facility and a liquor store). In the Commission's view, these can be dealt with on a case-by-case basis.

Accordingly, this proposal would eliminate the automatic prohibition in N.J.A.C. 19:50-1.4(d) against certain combinations of CHAB authorizations. However, in doing so, the Commission again emphasizes that it will reserve the right to reject any combination of CHAB authorizations which may not be appropriate.

The other two amendments involve an issue raised by the recent introduction of simulcasting. The Commission's regulations were recently amended to provide for casino simulcasting facilities, see 25 N.J.R. 348(b). At that time, the Commission's casino hotel alcoholic beverage (CHAB) regulations were also amended to address the service and consumption of alcoholic beverages in casino simulcasting facilities. See N.J.A.C. 19:50-1.4(a)6.

When the Commission's CHAB regulations were subsequently re-adopted, the Division of Gaming Enforcement (Division) suggested two additional technical amendments to N.J.A.C. 19:50-1.5(d) and (e), to include references to the new Type VI (casino simulcasting facilities) CHAB locations. Because those amendments were beyond the scope of the readoption proposal, the Commission determined to address the suggestions in a later proposal, and is doing so now.

**Social Impact**

These amendments to the CHAB regulations are technical in nature and are not expected to have any overall social impact. However, the lifting of the automatic prohibition of certain CHAB combinations allows the casinos the discretion to make business arrangements to address or not the concerns that arise from these combinations.

**Economic Impact**

The amendment permitting increased flexibility in multiple CHAB authorizations may give CHAB licensees some additional flexibility in the use of their facilities, enabling them to provide more efficient alcoholic beverage service, and possibly at a lower cost. The other amendments to the CHAB regulations are not expected to have any economic impact.

**Regulatory Flexibility Statement**

The proposed amendments would affect CHAB licensees, most of which are casino licensees that would not qualify as "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Certain other CHAB licensees may qualify as small businesses under the Regulatory Flexibility Act; these include individuals or other organizations that sell alcoholic beverages in a portion of the casino hotel which they occupy pursuant to a license or lease.

Although some small businesses are affected by these amendments, they constitute in fact a lessening of regulation and the objective of uniform regulation of alcoholic beverage service in all authorized CHAB locations in a casino hotel may be met only by imposing uniform compliance upon all CHAB licensees. Accordingly, no exemption or varying standard need be provided for small business in this instance.

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

19:50-1.4 Classification of authorized locations

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

(d) The Commission may, consistent with the requirements of (b) above, issue two or more types of authorizations for the same authorized location, or different types of authorizations for different areas of the same authorized location. [This subsection shall not apply to Type I, Type V or Type VI authorized locations.]

19:50-1.5 Standards for qualification

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

(d) No Type V authorization shall issue to any applicant who does not hold a Type I, II, III [or], IV **or VI** CHAB authorization.

(e) Every employee and agent of a CHAB licensee whose employment or agency includes duties in, on, or about the premises, but not in a Type I **or Type VI** authorized location, shall be registered as a casino hotel employee in accordance with section 91 of the Act.

(f) (No change.)

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# (a)

## CASINO CONTROL COMMISSION

### Casino Hotel Alcoholic Beverage Control
### Conduct of CHAB licensees
### Additional Operating Conditions of CHAB Licensees
### Proposed Amendments: N.J.A.C. 19:50-2.2

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(q) and 103.

Proposal Number: PRN 1993-439.

Submit written comments by September 15, 1993 to:
Seth H. Briliant, Assistant Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

**Summary**

The Commission acknowledges that the service of alcoholic beverages in casino hotels and on the casino floor is a customary and necessary component to the hospitality industry. Used appropriately and in moderation, an alcoholic beverage can contribute to a patron's enjoyment of casino gaming and the gaming experience. The Commission also recognizes and is extremely concerned about the serious problems which could occur if a casino patron is permitted to gamble while intoxicated.

The basic regulatory apparatus needed to deal with this concern is already in place. The New Jersey Division of Alcoholic Beverage Control (ABC) has a long-standing regulation, N.J.A.C. 13:2-23.1(b), which prohibits a liquor licensee from selling or allowing the sale of alcoholic beverages to any person who is actually or apparently intoxicated. The Casino Control Act and the Commission's casino hotel alcoholic beverage (CHAB) regulations incorporate that ABC regulation by reference, see N.J.S.A. 5:12-103(d) and N.J.A.C. 19:50-2.1.

The difficulty arises in the systematic application of the above principle. Usually, the final decision and the ultimate responsibility for alchoholic beverage service falls to a cocktail server or a dealer, who may have been observing the patron for some time, and is therefore in the best position to judge the situation. However, these employees may be afraid to speak up and take appropriate action by refusing to serve, or to permit service of alcoholic beverages to the patron, for fear of offending the patron and thereby suffering possible retribution by their employer.

But, in the Commission's view, these employees are really the first line of defense in this particular situation; they have an affirmative obligation to take action when necessary, and the Commission would encourage them to exercise their judgement in this area. Accordingly, the first proposed amendment, N.J.A.C. 19:50-2.2(g), is modeled in part upon the "Conscientious Employee Protection Act," N.J.S.A. 34:19-1. This amendment would expressly prohibit a CHAB licensee from firing, demoting, disciplining or taking other adverse action against an employee who refuses to serve or permit the service of alcoholic beverages to a person who is apparently or actually intoxicated, or who refuses to deal to such a person or permit wagering by that person.

The other proposed amendment, N.J.A.C. 19:50-2.2(h), is intended to aid in the implementation of the foregoing Commission alcoholic beverage policy. It would provide for documentation, by Commission employees or agents of the Division of Gaming Enforcement, of situations where a patron is actually or apparently intoxicated. Such documentation could be requested by any CHAB licensee or any patron or employee thereof. It could be requested to protect a licensee from

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possible claims by a patron, to protect the claims of an employee exercising his or her rights under the proposed "whistleblower" amendment, N.J.A.C. 19:50-2.2(g), or to protect the claims of a patron.

The contemporaneous recording of such documentation would be available in the event that subsequent civil, criminal or administrative proceedings arose in which a patron's intoxication is an issue. It should also be noted that the function of Commission employees would be strictly an evidentiary one; if any violations of Commission regulations or applicable statutes are observed during such documentation, the observations would be forwarded to the Division of Gaming Enforcement, for such action as it may deem necessary.

**Social Impact**

These proposed amendments are intended to reduce and prevent potential problems associated with gaming by intoxicated patrons, and to discourage CHAB licensees and their employees from serving intoxicated patrons, dealing to them, or permitting them to place wagers. The proposed amendments would also provide a means to create an independent record for such licensees and their employees and patrons, if subsequent civil, criminal or administrative proceedings arose in which a patron's intoxication is an issue.

**Economic Impact**

The economic impact of the proposed amendments is unknown. However, if they do prevent or reduce the types of alcoholic beverage incidents described above, the potential or actual liability of CHAB licensees may also be reduced, resulting in an economic benefit to these licensees.

**Regulatory Flexibility Statement**

These proposed amendments would affect CHAB licensees, most of which are also casino licensees that would not qualify as "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Certain other CHAB licensees may qualify as small businesses under the Regulatory Flexibility Act; these include individuals or other organizations that sell alcoholic beverages in a portion of the casino hotel which they occupy pursuant to a license or lease.

Although some small businesses are affected by these amendments, the objective of uniform regulation of alcoholic beverage service in all authorized CHAB locations in a casino hotel may be met only by imposing uniform compliance upon all CHAB licensees. Accordingly, no exemption is provided for small business in this instance.

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

19:50-2.2 Additional operating conditions of CHAB licensees

(a)-(f) (No change.)

**(g) No CHAB licensee shall discharge, suspend, discipline or demote an employee, or take any other action which would be adverse to the terms and conditions of his or her employment, by reason of the refusal of the employee, with regard to any person who is actually or apparently intoxicated, to:**

**1. Serve, or allow, permit or suffer the service of alcoholic beverages to such person;**

**2. Allow, permit or suffer the consumption of any alcoholic beverage in or upon the licensed premises by such person;**

**3. Deal any game, or allow, permit or suffer the dealing of a game to such person; or**

**4. Allow, permit or suffer the placement of a wager by such person.**

**(h) At the request of a CHAB licensee or any patron or employee thereof, any Commission employee or agent of the Division may observe and document, request a videotaping by the Division or surveillance department, or otherwise record the physical condition, appearance and activities of any person who is or is claimed to be actually or apparently intoxicated. The Commission shall refer to the Division for appropriate action any evidence of a violation of Commission regulations or applicable provisions of N.J.S.A. 33:1-1 et seq. and N.J.A.C. 13:2.**

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# (a)

## CASINO CONTROL COMMISSION

## Casino Hotel Alcoholic Beverage Control Conditions of Operation in Type I (Casino) and Type VI (Casino Simulcasting Facilities) Locations

## Proposed Amendments: N.J.A.C. 19:50-3.1 and 3.6

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(q) and 103(g)1 and (g)6.

Proposal Number: PRN 1993-437.

Submit written comments by September 15, 1993 to:
Seth H. Briliant, Assistant Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, N.J. 08401

The agency proposal follows:

**Summary**

Section 103(g)1 of the Casino Control Act (the Act), N.J.S.A. 5:12-103(g)1, provides that alcoholic beverages may be served on the casino floor. The Act does not specify or prohibit any particular mode of service, indicating only that such service must be at a patron's request. Additionally, N.J.A.C. 19:50-3.1(d) and 3.6(d) prohibit the display of alcoholic beverages on the casino floor and in casino simulcasting facilities, except where "incidental to delivery or consumption by a patron." These regulations are based upon the theory that certain displays of alcoholic beverages could be construed to be offers of alcoholic beverages, in violation of the section 103(g)(1) prohibition against such unsolicited offers.

Several casino hotel alcoholic beverages (CHAB) licensees which are also casino licensees recently requested permission to place bars on the casino floor and in proposed casino simulcasting facilities, to supplement the cocktail servers now in use. Such requests raise the question whether the mere presence of an operating bar in these locations constitutes an unsolicited offer of alcoholic beverages, in violation of section 103(g)1 and the CHAB display prohibitions.

In the Commission's opinion, a bar would not, in and of itself, constitute an unlawful unsolicited offer. While there may be other items or activities which might violate the statutory prohibition against unsolicited alcoholic beverage offers, for example, certain signage, language or actions, a bar is not considered to be one of them. This would be true whether the bar serves pay drinks or complimentary drinks, which are also permitted by the Act and are customarily served on the casino floor.

Similarly, without specifically indicating what other arrangements might violate the CHAB display regulations, the Commission believes that N.J.A.C. 19:50-3.1(d) and 3.6(d) do not prohibit the display of a moderate amount of liquor at such bars. Beer taps, "speed racks," and similar temporary storage of open liquor bottles, as well as a small stock of sealed replacement bottles, are customary and necessary at an operating bar. In the Commission's view, such items are "incidental to delivery" of alcoholic beverages, and therefore come within the exceptions to the display prohibitions.

The proposed amendments to the CHAB regulations would codify the above position by indicating that CHAB licensees may operate bars on their casino floors and in their casino simulcasting facilities, and may display therein the alcoholic beverages required for the normal operation of such a bar.

**Social Impact**

Alcoholic beverages are already permitted to be served on the casino floor and in a casino simulcasting facility. The present prohibitions against serving alcoholic beverages to minors and intoxicated persons (see N.J.A.C. 19:50-2.1 and N.J.A.C. 13:2-23.1), as well as service only upon a patron's request (N.J.A.C. 19:50-3.1(a) and 3.6(a)), would still apply to alcoholic beverage service in these gaming areas, whether service is by a cocktail server or a bartender. Accordingly, these amendments are expected to have little, if any, social impact.

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**Economic Impact**

The economic impact of these amendments is not known at this time. The expense of constructing bars in gaming areas, with the resulting loss of floor space and gaming revenue to the casinos in those areas, may or may not justify the possible increased efficiency in service that these proposed bars may provide.

**Regulatory Flexibility Statement**

The proposed amendments will affect only New Jersey CHAB licensees which are also casino licensees operating casinos or casino simulcasting facilities. None of these licensees is a "small business" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq. Accordingly, a regulatory flexibility analysis is not required.

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

19:50-3.1 Conditions of operation in Type I (casino) locations

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

(d) No alcoholic beverage shall be displayed in a Type I location except [incidental]:

**1. As required for the necessary operation of a bar;**

**2. During the customary and ordinary course of preparing a patron's drink order; or**

**3. Incidental** to delivery or consumption by a patron.

(e) (No change.)

19:50-3.6 Conditions of operation in Type VI (casino simulcasting facility) locations

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

(d) No alcoholic beverage shall be displayed in a Type VI location except [incidental]:

**1. As required for the necessary operation of a bar;**

**2. During the customary and ordinary course of preparing a patron's drink order; or**

**3. Incidental** to delivery or consumption by a patron.

(e) (No change.)

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# (a)

## CASINO CONTROL COMMISSION

## Equal Employment and Business Opportunity Advisory Boards; Employment Goals; Job Categories; Atlantic City Small Businesses

## Proposed Amendments: N.J.A.C. 19:53-1.3, 1.5, 2.3, 4.4, 6.2 and 6.6

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63, 69, 75, 134 and 135.

Proposal Number: PRN 1993-462.

Submit written comments by September 15, 1993 to:
David C. Missimer, Assistant General Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

**Summary**

On July 21, 1993, the Commission voted to adopt a new chapter of rules concerning the equal opportunity and affirmative action obligations which are imposed on persons regulated by the provisions of the Casino Control Act, N.J.S.A. 5:12-1 et seq. A copy of the Notice of Adoption for the adopted new rules may be found in the Adoption section of this issue of the New Jersey Register. As a result of certain comments received in response to the publication of the proposed new chapter and upon the Commission's own further review of the rules, the Commission determined to propose several amendments to the new chapter at the time the new rules were adopted.

The amendment to N.J.A.C. 19:53-1.5 is being proposed as a result of various comments received from organizations which represent the interests of the disabled. These commenters felt that the new rules should not be adopted because they failed to provide disabled persons with the same type of affirmative action benefits which were being afforded women and minorities. These commenters asserted that the casino industry had an extremely poor record of hiring disabled persons. As a result, many of the commenters also opposed the elimination of reporting obligations for licensees and applicants as to the number of disabled persons who were employed by these entities. Conversely, the Commission received a comment from an individual actively involved in the local disabled community who asserted that the casino industry in Atlantic City had a better record of assisting disabled persons with employment opportunities than almost any other major business. This comment is consistent with other factual information which the Commission has been able to garner over the past several years concerning the employment opportunities afforded disabled persons by the casino industry. A more detailed summary of these comments and the Commission's responses thereto may be found in the Notice of Adoption.

Based on this record, the Commission concluded that it would be premature at this time to impose any additional obligations on casino licensees or applicants concerning employment opportunities for the disabled. The inability of the Commission to obtain accurate information about the employment status of disabled persons in the casino industry is due in large part to the different factual and legal issues which must be confronted when trying to gather such information. As noted in the Notice of Adoption, the obvious unreliability of the information which was being obtained in this area was the reason that the Commission eliminated the reporting requirement in the new rules. One of the commenters on the new rules, the Rutgers University Bureau of Economic Research, has given the Commission cause to hope that this reporting problem may be resolvable.

The Commission has therefore decided that the most appropriate way to resolve the conflicting assertions with which it is currently confronted would be to mandate the creation of a separate advisory board to consider issues which relate to the participation of disabled persons in the casino industry. As indicated in the proposed amendment to N.J.A.C. 19:53-1.5, this advisory board would consist of representatives of the regional disabled community, advocacy groups for the disabled and casino licensees. One of its initial goals would be to develop an accurate and reliable means of measuring the participation of disabled persons in the casino industry so that the Commission would be in a better position to know whether any further regulatory or remedial actions are in fact required. The advisory board would have the responsibility to make recommendations for specific regulatory proposals to the Commission should such actions be deemed appropriate. A corresponding amendment to N.J.A.C. 19:53-6.2, the general regulatory section of the Equal Employment and Business Opportunity Plan (EEBOP), is proposed to make sure that casino licensees and applicants make provisions in their EEBOPs to assist and support the efforts of the advisory board.

The proposed amendments to N.J.A.C. 19:53-2.3 and 4.4, which establish employment goals for women and minorities in the construction work force and operations work force, respectively, are based upon a Commission reevaluation of the standards upon which these goals should be based. The casino industry, in commenting on the new rules, suggested that the Commission should use individual goals for each EEOC job category and that these goals should be based on the number of employees in the comparative work force who are actually available to fill such positions. The Commission reviewed the 1990 U.S. Census data and analysis supplied by the casino industry, and determined to propose various modifications to the employment goals contained in the rules.

In general, the women and minority employment goals proposed by the Commission for each EEOC job category are based upon the higher of normalized casino industry employment or cumulative Atlantic County work force statistics. There are two exceptions to this general rule. First, the goals for any particular job category are designed so that they do not exceed the percentage of the cumulative Atlantic County work force statistic for that class (that is, 46 percent for women and 25 percent for minorities). Second, if the Atlantic County availability data for a particular EEOC job category is significantly below (more than 10 percent) the cumulative Atlantic County work force statistic for that class, the employment goal for that particular EEOC category and class will be the Atlantic County availability statistic. The proposed employment goals contained in the amendments to N.J.A.C. 19:53-2.3 and 4.4 are based upon the application of these principles to the 1990 U.S. Census data for the Atlantic County work force and the Commission's casino industry work force composition analysis.

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The amendment being proposed to N.J.A.C. 19:53-1.3 is based on informal discussions which the Commission has held with the casino industry since the comment period on the new rules expired. Upon additional review of the new chapter, the casino industry recommended that the salary floor for Subclass IV of the Officials and Managers job category (see N.J.A.C. 19:53-1.3(b)1iv.) be reduced so as to capture supervisors who met the functional definition of the job category but did not earn $35,000. The proposed amendments to this section, in addition to implementing this suggestion, reduces the number of subclasses to three. The three new subclasses are intended to more accurately reflect the three traditional levels of supervision: senior management, middle management and front-line supervisors.

The proposed amendment to N.J.A.C. 19:53-6.6 would modify the definition of Atlantic City small business to include a company which has more than 50 full time employees if at least 80 percent of its full time employees are permanent residents of Atlantic City. The Commission believes that this amendment is consistent with the statutory goal of revitalizing Atlantic City. The proposed amendment will permit larger Atlantic City firms which can have a significant economic impact on the City through the location of their work force to benefit from the programmatic development efforts of casino licensees encouraged by N.J.A.C. 19:53-6.6.

**Social Impact**

The proposed amendments to N.J.A.C. 19:53-1.5 and 6.2 should not have any immediate social impact other than to help to determine, once and for all, whether disabled persons are in fact being afforded equal opportunity by the casino industry. Should the advisory board determine that regulatory or remedial measures should be recommended for implementation by the Commission, the derivative social impact of the proposed rule on disabled persons could be significant.

The social impact of the proposed revisions to the employment goals contained in N.J.A.C. 19:53-2.3 and 4.4 on members of the general work force will vary depending upon the particular job category to which they belong. For example, the amendments will not affect the affirmative action employment goals for women in five of the nine EEOC job categories, and thus should have little if any social impact on individuals who hold positions or skills in these categories. By contrast, the proposed amendments would, based on availability data, revise the employment goals for women in craftpersons positions from seven percent to five percent and for minorities in craftpersons positions from 22 percent to 14 percent.

The proposed amendments to N.J.A.C. 19:53-1.3 are not anticipated to have any significant social impact. Certain supervisors who made less than $35,000 and thus would have been placed in a job category other than Officials and Managers will now be counted in the job category which is consistent with their job functions. The proposed amendments should therefore allow the Commission to assess the employment practices of casino licensees more accurately.

The proposed amendment to N.J.A.C. 19:53-6.6 should give more Atlantic City businesses the opportunity to participate in the business development programs which casino licensees choose to initiate pursuant to the provisions of their approved EEBOPs. This should benefit both the businesses themselves and the Atlantic City community.

**Economic Impact**

Similar to the social impact analysis presented above, the economic impact of the proposed amendments to N.J.A.C. 19:53-1.5 and 6.6 will depend in large measure on the actual activities of the advisory board which would be created rather than on the creation of the board itself. It is anticipated that there will be some administrative costs to casino licensees and the regulatory agencies associated with the operation of the board but these costs should not be significant.

The economic impact of the proposed amendments to the employment goal sections of the rules on casino licensees and applicants would be highly speculative since some employment goals will increase and some goals will decrease. The impact of the proposed amendments on individual members of the work force, as indicated above, will depend upon their particular position in the work force and the increase or decrease in the goals for the job category in which their position falls.

The potential economic impact of the proposed amendment to N.J.A.C. 19:53-6.6 should be positive for enterprises which will satisfy the revised definition and for the economy of Atlantic City. The actual impact will depend, of course, on the extent to which casino licensees choose to participate in the development programs anticipated by the section and the number of qualifying companies who are selected for inclusion.

The proposed amendment to N.J.A.C. 19:53-1.3 will require casino licensees and applicants to reclassify certain of their employees into the Officials and Managers job category. The amendment should not have any significant economic impact on any member of the public or the regulatory agencies.

**Regulatory Flexibility Statement**

The proposed amendments primarily affect casino licensees and applicants and individual employees thereof, none of which qualify as a small business under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Certain enterprises which may qualify as a small business may be affected by the proposed amendment to N.J.A.C. 19:53-6.6; however, no reporting, recordkeeping or compliance requirements will be imposed on such enterprises as a result of the amendment. Therefore, a regulatory flexibility analysis is not necessary.

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

19:53-1.3 Classification of employees; use of EEOC job categories

(a) Whenever the rules in this chapter require a licensee or applicant to classify employees or job titles by job category, the licensee or applicant shall use the nine broad occupational classifications developed by the U.S. Equal Employment Opportunity Commission (EEOC), as adapted or modified by the rules of the Commission in (b) below. When required, the licensee or applicant shall also provide data concerning the [four] **three** subclasses of Officials and Managers as described in (b) below.

(b) The EEOC job category classifications and subclassifications to be used by licensees and applicants are, in order, as follows:

1. "Officials and Managers" are occupations in which employees set broad policies, exercise overall responsibility for implementation of these policies, direct individual departments or special phases of the organization's operations, provide specialized consultations on a regional, district or area basis, or supervise or assist in the supervision of specific work units. This category shall include, without limitation, occupations such as chief executive officer, president, vice president, director, assistant director, equal opportunity officer, manager, assistant manager, pit boss, shift supervisor, floorperson and boxperson. Unless otherwise specified in an approved EEBOP, this category shall consist of [four] **three** subclassifications defined by compensation range as follows:

i. "Subclass I" are positions whose actual salaries are [$95,000] **$75,000** and above.

ii. "Subclass II" are positions whose actual salaries are from [$75,000 to $94,999] **$35,000 to $74,999**.

iii. "Subclass III" are positions whose actual salaries are [from $55,000 to $74,999] **less than $35,000**.

[iv. "Subclass IV" are positions whose actual salaries are from $35,000 to $54,999.]

2.-9. (No change.)

19:53-1.5 Advisory [board] **boards**

**(a)** The Commission may establish an advisory board consisting of local or State officials, representatives of area businesses and communities, women and minority organizations, union officials, disabled persons, casino industry representatives or other interested parties. Such advisory board may make recommendations to the Commission, upon its request, concerning policies or techniques to assure equal employment opportunity for all persons and the participation of certified and provisionally certified MBEs and WBEs in purchasing and contracting in the casino industry and the casino-related construction industry.

**(b) The Commission shall establish an Advisory Board on the Disabled to consider issues affecting disabled persons and the casino industry. This advisory board shall consist of members of the regional disabled community, representatives of organizations which advance the interests of the disabled and representatives of the casino industry. The purpose of the advisory board shall be to identify, investigate, and make recommendations to the Commission**

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**concerning issues which affect the ability of disabled persons to obtain employment and business opportunities with the casino industry. Such recommendations may include, at the discretion of the advisory board or upon request by the Commission, suggestions for the promulgation of specific regulations. The advisory board may also develop and recommend to the Commission a program which will permit the accurate identification and reporting of disabled persons who are employed by or doing business with the casino industry.**

19:53-2.3 Women and minority employment goals for the construction work force of casino licensees and applicants

(a) Unless otherwise specified in an approved EEBOP pursuant to N.J.A.C. 19:53-6, the women and minority employment goals for the construction work force of a casino licensee or applicant and its individual contractors and subcontractors shall be [seven] **five** percent for women journeyworkers and apprentices and [22] **14** percent for minority journeyworkers and apprentices.

(b) (No change.)

19:53-4.4 Women and minority employment goals for the operations work force of casino licensees and applicants

[(a)] Unless otherwise specified in an approved EEBOP pursuant to N.J.A.C. 19:53-6, the women and minority employment goals for the operations work force of a casino licensee or applicant [shall be 46 percent for women and 22 percent for minorities for each EEOC job category except craftpersons, which shall be subject to the applicable women or minority employment goal established pursuant to N.J.A.C. 19:53-2.3.

(b) Subject to the availability of comparable occupational data for Atlantic County concerning levels of employment of women and minorities in the eight EEOC job categories other than craftpersons, the Commission may promulgate employment goals for women and minorities for each of these eight EEOC job categories. If job category goals are promulgated, each specific job category goal shall be used by a casino licensee or applicant instead of the goals specified in (a) above.] **, by EEOC job category, shall be as follows:**

| EEOC JOB CATEGORY | MINORITY GOAL (PERCENTAGE) | FEMALE GOAL (PERCENTAGE) |
|---|---|---|
| **Officials and Managers** | **25** | **46** |
| **Professionals** | **25** | **46** |
| **Technicians** | **25** | **46** |
| **Salesworkers** | **25** | **46** |
| **Office and Clerical** | **25** | **46** |
| **Craftpersons** | **14** | **5** |
| **Operatives** | **25** | **30** |
| **Laborers** | **25** | **14** |
| **Serviceworkers** | **25** | **46** |

19:53-6.2 General regulatory section of an EEBOP

(a) (No change.)

(b) Other topics appropriate for inclusion in the general regulatory section of an EEBOP shall include, without limitation, the following:

1. (No change.)

2. A description of the lines of communication and reporting within the organization as they relate to the objectives of this chapter; [and]

**3. A description of the resources which the casino licensee or applicant will make available to the advisory boards organized pursuant to the provisions of N.J.A.C. 19:53-1.5 and a commitment by the casino licensee or applicant to actively participate in and support the efforts of these advisory boards; and**

[3.]**4.** A description of the procedures and techniques which the casino licensee or applicant will use to monitor implementation of the EEBOP and to assess the need for modifications.

19:53-6.6 Atlantic City small businesses

(a) In order to further the statutory goal of revitalizing Atlantic City as set forth in section 1 of the Act, each casino licensee and applicant shall be encouraged to include in its EEBOP strategies and objectives which are intended to foster the development of Atlantic City small businesses. For the purposes of this section, an "Atlantic City small business" shall be defined as a sole proprietorship, partnership or corporation:

**1.** [whose] **Whose** management owns at least 51 percent of the business and is responsible for its daily and long-term operation[,];

**2. Which either** has 50 or fewer full-time employees **or is a firm with full-time employees at least 80 percent of whom are permanent residents of Atlantic City;** and

**3. Which** has its principal place of business (the location where the majority of its employees are located or based) in Atlantic City.

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

# COMMUNITY AFFAIRS

## (a)

## DIVISION OF HOUSING AND DEVELOPMENT

### Uniform Construction Code
### Minor Work; Ordinary Repairs
### Proposed Amendments: N.J.A.C. 5:23-1.4, 2.7 and 2.17A

Authorized By: Stephanie R. Bush, Commissioner, Department of Community Affairs.

Authority: N.J.S.A. 52:27D-124.

Proposal Number: PRN 1993-431.

Submit written comments by September 15, 1993 to:
Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

Although the Department has always considered the installation of radon mitigation systems in detached one- and two-family dwellings to be minor work, this was not made clear in the rules. These proposed amendments would remedy that oversight. The installation of these systems in one- and two-family detached dwellings does not require plan review.

Also included in the amendments is a revision of the definition of "minor work" to eliminate the requirement that not more than one trade be involved. The installation of low pressure water heaters, dishwashers and garbage disposals, though they may involve more than one trade, should all properly be regarded as minor work. The true test of minor work is that no prior approval or plan review is necessary and that in no way does the work alter the structural members of the building.

The Department also proposes to make it clear that the installation of a fire-detection or suppression device is minor work, but that detection or suppression systems are not. In addition, low voltage communication systems are minor work, except in one- and two-family dwellings, where they are classified as ordinary repairs. Work on drain leaders is no longer to be excluded from the category of ordinary repairs (see also 25 N.J.R. 2159(a)).

**Social Impact**

The effect of having a clearer definition of "minor work" and what it encompasses will be that the permit process will be more efficient and that work that qualifies as "minor work" may proceed on a more expedited basis.

**Economic Impact**

These changes will allow for more "minor work" to be done on a more expedited basis. This will result in lower costs to contractors, which may then be passed on to consumers. In addition, since plan review is not required for minor work, this clarification will help to reduce the workload in construction code offices. Persons applying for permits to install fire detection or suppression systems may encounter additional costs due to the need to file plans and allow time for them to be reviewed. The cost would vary depending on the size and complexity of the job.

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**Regulatory Flexibility Statement**

The proposed amendments will benefit "small businesses," as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., to the same extent that it will benefit any other property owners who are doing work that may be classified as "minor work." No added requirements are imposed upon any property owner by these amendments. Therefore, a regulatory flexibility analysis is not required.

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

5:23-1.4 Definitions

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

...

"Minor work" means construction work [of a single trade only] undertaken in existing structures, requiring no prior approvals and no plan review, not altering in any way the structural members of a building and meeting the definition set forth in N.J.A.C. 5:23-2.17A.

...

5:23-2.7 Ordinary repairs

**(a)** Ordinary repairs to structures may be made without application or notice to the construction official[, but such]**.**

**(b) Such** repairs shall not include **any of** the **following:**

**1. The** cutting away of any wall, partition or portion thereof [, the]**;**

**2. The** removal or cutting **away** of any structural beam or bearing support[, or the]**;**

**3. The** removal or change of any required means of egress, or rearrangement of parts of a structure affecting the exitway requirements[, or any]**;**

**4. Any** work affecting structural or fire safety[, or any]**;**

**5. Any** work [which] **that** will increase the nonconformity of any existing building or structure with the requirements of the regulations; [nor shall ordinary repairs include addition]

**6. Addition** to, **or** alteration [of], replacement or relocation of**:**

**i.** [any] **Any** standpipe**;**

**ii.** [, water] **Water** supply, sewer, drainage, [drain leader,] gas, soil, waste, vent or similar piping**;**

**iii.** [, electric] **Electrical** wiring**, other than wiring for a low voltage communication system in a one- or two-family dwelling;** or

**iv.** [mechanical] **Mechanical** or other work affecting public health or general safety.

5:23-2.17A Minor work

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

(c) Minor work:

1.-3. (No change.)

4. Minor work shall also mean and include the installation of any fire detection or suppression [system or] device in any one- or two-family [home] **dwelling; installation of a radon mitigation system in an existing detached one or two-family dwelling;** [and] the installation of a burglar alarm[,] **or** security[, or low voltage communication] system in any structure **and the installation of a low voltage communication system in any structure other than a one- or two-family dwelling.**

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## (a)

## DIVISION OF HOUSING AND DEVELOPMENT

### Uniform Construction Code

### Municipal Enforcing Agencies; Administration and Enforcement

### Proposed Amendment: N.J.A.C. 5:23-4.5

Authorized By: Stephanie R. Bush, Commissioner, Department of Community Affairs.

Authority: N.J.S.A. 52:27D-124.

Proposal Number: PRN 1993-430.

Submit comments by September 15, 1993 to:

Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, NJ 08625
FAX No. (609) 633-6729

The agency proposal follows:

**Summary**

During the course of an elevator inspection, an inspector may discover mechanical defects or conditions that render the elevator, or other device subject to N.J.A.C. 5:23-12 (escalator, moving walk, platform lift), so dangerous as to render it a life hazard that must be shut out of service until it can be repaired or replaced. In these instances, the device is to be marked with a dated placard identifying the device, stating the hazard and forbiding its use. This placard is designated "F-325, Notice of Elevator Device Sealed Out of Service" and is one of the Department's standard forms. The proposed amendment adds this form to the list of standardized forms at N.J.A.C. 5:23-4.5(b)2.

**Social Impact**

The use of Form F-325 will ensure that a standard form with the above necessary information is used by inspectors sealing dangerous elevator devices out of service. This form, if used as required, will ensure that the public is duly notified and protected from the danger of a malfunctioning elevator device.

**Economic Impact**

The placard to be printed can be processed in the same manner as other standard forms and any additional cost for printing should be negligible in the total printing budget.

**Regulatory Flexibility Analysis**

This form is required to be used by all enforcing agencies, including private enforcing agencies that may qualify as "small businesses," as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The cost burden on all enforcing agencies will be minimal and, even if it were not, the need for uniformity in enforcement procedures in the interest of public health, safety and welfare would make equal compliance by all enforcing agencies necessary.

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

5:23-4.5 Municipal enforcing agencies; administration and enforcement

(a) (No change.)

(b) Forms:

1. (No change.)

2. The following standardized forms established by the Commissioner are required for use by the municipal enforcing agency:

...

| | |
|---|---|
| F-320A | Elevator Notice |
| **F-325** | **Notice of Elevator Device Sealed Out of Operation** |

...

3.-5. (No change.)

(c)-(j) (No change.)

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## (b)

## DIVISION OF HOUSING AND DEVELOPMENT

### Planned Real Estate Development

### Community Associations; Meetings

### Proposed Amendment: N.J.A.C. 5:26-8.2

Authorized By: William M. Connolly, Director, Division of Housing and Development, Department of Community Affairs.

Authority: N.J.S.A. 45:22A-35.

Proposal Number: PRN 1993-420.

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Submit written comments by September 15, 1993 to:
Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, NJ 08625
FAX No. (609) 633-6729

The agency proposal follows:

**Summary**

The proposed amendment provides that all meetings of community associations that are required by law to be open to all unit owners shall be held at a location within the development or, if there is no suitable meeting room within the development, at a suitable meeting room located elsewhere in the municipality in which the development is located. A meeting room shall not be deemed to be suitable if it is not large enough to accommodate a reasonable number of unit owners who might wish to attend an open meeting.

**Social Impact**

This proposed amendment would allow unit owners a realistic opportunity to exercise their right, pursuant to P.L. 1993, c.30, to be present at meetings of community associations that are required to be open to all unit owners.

**Economic Impact**

It is possible that a community association that does not have a suitable meeting room may have to incur costs in order to make alternative arrangements. It is not the Department's intention to require sufficient seating for all members of the association, anymore than any muncipal building in any but the smallest municipalities has seating for all residents in its meeting room. However, there must be sufficient seating for as many people as would be expected normally to attend a meeting at which a matter of substance would be under discussion.

**Regulatory Flexibility Statement**

Whether this proposed amendment will impose any burden upon a community association will depend upon whether there is a meeting room readily available to the association that conforms to the requirements of the amendment. The Department infers a clear intention in P.L. 1993, c.30 that meetings that are required by law to be open to unit owners should not be effectively closed to them by being held in remote locations or in rooms that cannot accommodate an audience of a size that is reasonable under the circumstances. These considerations apply regardless of whether the association might qualify as a "small business" under the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

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

5:26-8.2 Powers and duties

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

**(d) All meetings of the association that are required by law to be open to all unit owners shall be held at a location within the development or, if there is no suitable meeting room within the development, at a suitable meeting room elsewhere in the municipality in which the development is located.**

**1. A meeting room shall not be deemed to be suitable if it is not large enough to accommodate a reasonable number of unit owners who might wish to attend an open meeting.**

# ENVIRONMENTAL PROTECTION AND ENERGY

## (a)

## SITE REMEDIATION PROGRAM

### Notice of Opportunity for Comment

### Analysis of Strict, Joint and Several Liability under the New Jersey Spill Compensation Act

**Take notice** that the Department of Environmental Protection and Energy ("Department"), in consultation with the Office of the Attorney General, in accordance with §48 of P.L. 1993, c.139, is preparing a report to be issued to the Governor and the New Jersey State Legislature concerning the effectiveness and fairness of the imposition of strict, joint and several liability on persons who have discharged, or are in any way responsible for, a hazardous substance pursuant to the New Jersey Spill Compensation Act, N.J.S.A. 58:10-23.11 et seq. The report, due in March 1994, will:

1. Analyze methods to expedite the securing of funding for the remediation of hazardous discharge sites;
2. Analyze methods to reduce the transactions costs associated with liability determinations;
3. Examine the historical and legal basis for the strict, joint and several liability standard;
4. Discuss the effect on the Department's remediation program of modifying the standard and replacing it with another standard of liability;
5. Review and discuss methods to enhance the fairness of the liability standard, including the possible use of mixed public and private funding for site remediations and the use of de minimis settlements for potential parties; and
6. Contain recommendations for future legislative or regulatory initiatives.

The Department and the Office of the Attorney General invite members of the regulated community, members of the New Jersey Bar, private and public interest groups and members of the general public to submit written comments concerning the effectiveness and fairness of the strict, joint and several liability standard. **Interested persons** wishing to submit comments may do so until September 15, 1993. Comments should be directed to:

John F. Dickinson, Jr.
Deputy Attorney General
Department of Law and Public Safety
Hazardous Site Litigation Section
Hughes Justice Complex
CN 093
Trenton, New Jersey 08625

# HUMAN SERVICES

## (b)

## CONTRACT POLICY AND MANAGEMENT UNIT

### Contract Administration

### Proposed Readoption with Amendments: N.J.A.C. 10:3

Authorized By: William Waldman, Commissioner, Department of Human Services.
Authority: N.J.S.A. 30:1-12.
Proposal Number: PRN 1993-454.

Submit comments by September 15, 1993 to:
Henrietta Small, Manager
Contract Policy and Management Unit
Department of Human Services
CN 700
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

N.J.A.C. 10:3 is due to expire November 21, 1993, in accordance with the sunset provisions of Executive Order No. 66(1978). The Department of Human Services proposes to readopt N.J.A.C. 10:3. The Department has reviewed the rules set forth in Chapter 3 and has found that they continue to be necessary and proper for the purposes for which they were originally promulgated.

On March 7, 1978, Ann Klein, then Commissioner of the Department of Human Services, adopted N.J.A.C. 10:3-1, Debarment, Suspension and Disqualification of a Person(s), in accordance with Executive Order 34 so that all persons supplying goods or services to the Department of Human Services meet a standard of responsibility which ensures the State and its citizens honest performance and avoidance of secret or illicit dealings.

N.J.A.C. 10:3-1, Debarment, Suspension and Disqualification of a Person(s) sets forth rules governing the exclusion of a provider from eligibility for consideration in the granting of contracts for goods or

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services by the Department of Human Services. The rules specify that a permanent exclusion must be based on the past performance and a history of lack of responsibility evidenced by offense, failure or inadequacy of performance for a period of time appropriate to the circumstances. A suspension, on the other hand, is a temporary exclusion that may be imposed pending completion of an investigation or legal proceeding.

N.J.A.C. 10:2, Capital Funding Program and Funding Agreement, sets forth the agreements to be used by the Department for capital planning projects. The New Jersey Public Purpose Buildings Construction Bond Act of 1980 (P.L. 1980 c.119) authorized the issuance of $159 million in state Bonds, of which a total of $75 million was allocated for the improvement, rehabilitation and construction of community-based facilities to benefit Department of Human Services clients classified as mentally retarded, mentally ill, or children in need of supervision. In response to the Bond Act, the Department established a capital funding program entailing contracting with private vendors and local government agencies to carry out the purposes of the act.

When the capital funding program was instituted, different contract documents were developed and employed by the departmental components involved in the program. In 1982, a decision was made to consolidate these departmental component-specific documents into standard versions usable across component lines. The standard document for construction, purchase or purchase and renovation of community-based facilities was finalized after publication in the New Jersey Register on September 19, 1983, a notice of adoption. The standard contract document for capital funding for renovation, remodeling, extension or other improvements to agency-owned or leased community facilities was proposed October 3, 1983, and adopted effective December 5, 1983 (see 15 N.J.R. 1627(a) and 2042(b)).

The New Jersey Human Services Facilities Construction Bond Act of 1984, P.L. 1984, c.157, created the "Human Services Construction Fund" for the continuation of funding for planning, construction, reconstruction, development, erection, acquisition, extension, improvement, rehabilitation and equipping of human services facilities. The standard contract document for planning and design services for community-based facilities was adopted November 21, 1988. In addition, the November, 1989 Public Purpose Buildings and Community Based Facility Construction Bonds Act, P.L. 1989, c.184, allocated a total of $90,000,000 to the Department of Human Services for expansion and improvements in its community based and institutional facilities. These funds will also require the use of the Capital Funding Agreements indicated in this rule. Consequently, a review of the current capital funding agreements revealed the continued need for the current consolidated standardized contract documents.

N.J.A.C. 10:3-3, Request for Proposal (RFP), establishes the policies and procedures by which a Departmental component, County Human Services Advisory Council (CHSAC) or other designated entity may request information from provider agencies for the provision of third-party social services to the Department's clients. This policy sets forth standardized Department-wide guidelines to be followed by the Departmental components and CHSACs/designated entities when an RFP is utilized.

There are several amendments proposed to the RFP policy. 10:3-3.1 and 3.2 have been changed to include the term designated entity. The new term will be used throughout the document. The term designated entity was added because there may be instances where other entities, aside from the Department and the CHSACs, may issue an RFP for the Department. This makes the policy more inclusive. The separation of N.J.A.C. 10:3-3.3(b) from N.J.A.C. 10:3-3.3(a) was made to clarify that the bidding conference was a separate process from that of the announcement of the RFP. Because of the change made to N.J.A.C. 10:3-3.11, it is necessary for the departmental component to have all information to comply with the State retention schedule; therefore, N.J.A.C. 10:3-3.5(g) is amended to require that all documentation be sent to the departmental component. And finally, N.J.A.C. 10:3-3.11 was updated to correspond with the document retention schedule of the State.

N.J.A.C. 10:3-4, Cognizant Contracting, sets forth the procedures and practices for contracting provider agencies that are funded by two or more departmental components within the Department of Human Services. Prior to the cognizant contracting rules, there was much duplication of required fiscal information forwarded to the individual departmental components contracting with the same provider agency. Cognizant contracting consolidates the fiscal requirements by selecting a cognizant or lead departmental component to negotiate (with prior input from the other components involved) all of the fiscal elements of the contract with the provider agency. Each departmental component maintains responsibility for the integrity and monitoring of its own programmatic proposals, which are independently prepared and forwarded to the cognizant component for inclusion in the proposal package prior to final negotiations with the provider agency.

**Social Impact**

This proposed readoption has potential social impact on two segments of the public: first, the community and the provider agencies with which the Department contracts; and secondly, the Department clients who benefit from such services and facilities.

With regard to the community and the provider agencies with which the Department contracts, the social impact of Chapter 3 can be considered favorable. Debarment, suspension and disqualification provisions protect the community and citizens from illicit dealings and provide for uniform application of policy. The consolidated standardized contract documents provide consistency and eliminate confusion, specifically for those agencies contracting with more than one departmental component, and incorporate terms and conditions application to all departmental components. The contract documents have been developed with input from and final approval by the Office of the Attorney General. The Request for Proposal will maintain the terms and conditions applicable to all departmental components, CHSACs or other designated entities and will provide consistency for those provider agencies which contract with more than one departmental component. In addition, these guidelines will provide the equity and clarity necessary to the decision making process. The proposed amendments will impose no change in the social impact on the provider agencies as the amendments apply to the Department. Cognizant contracting continues to eliminate duplicative paper work for those provider agencies that contract with more than one departmental component. In addition, cognizant contracting means more standardized and consistent practices regarding negotiation, approval, payment, and service delivery.

With regard to Department clients, the social impact of the adoption of the proposed rules is negligible. Clients have no direct involvement in the rules to be readopted.

**Economic Impact**

The proposed readoption will have no economic impact on the Department clients or any other members of the public at large.

The economic impact of this proposed readoption on the Department of Human Services and community provider agencies, while difficult to quantify, is positive. The protection provided by debarment, suspension and disqualification of provider agencies and the consolidated standard contract documents will ensure that contracts are administered and agencies treated consistently throughout the Department. The Request for Proposal rules may have had some new administrative costs associated with it when first adopted. However, the RFP process was used prior to the standardization required in these rules; therefore, at the initial adoption, the economic impact was minimal. The amendments now being proposed will cause no additional economic impact. Cognizant contracting changes only the administration of the Department's multi-funded contracts and, therefore, has no negative economic impact on the provider agencies.

**Regulatory Flexibility Analysis**

N.J.A.C. 10:3-1, Debarment, Suspension and Disqualification of a Person(s), and N.J.A.C. 10:3-2, Capital Funding Program and Funding Agreement, impose no recording, recordkeeping or specific requirements on small business as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. N.J.A.C. 10:3-3, Request for Proposal (RFP), sets the standards by which every provider agency replying to an RFP must comply. There are no recordkeeping or reporting requirements; however, each provider agency applying for funding through an RFP must follow N.J.A.C. 10:3, which sets forth compliance requirements and the information necessary to be considered for a contract with the Department of Human Services. The readoption of N.J.A.C. 10:3-3 establishes no need for the provider agencies to employ outside professional services to comply with the provisions of these rules, nor is there any requirement to expand capital cost to comply with the rules. As N.J.A.C. 10:3-3 was established to standardize the contract award process, it is essential that each agency submit the same type of information to ensure consistent and equitable review for a contract award. Finally, N.J.A.C. 10:3-4, Cognizant Contracting, changes only the admin-

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istration of the Department's multi-funded contracts. The rules lessen the paperwork required for the provider agencies and, in fact, benefit large and small businesses alike.

**Full text** of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:3.

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

10:3-1.2 Causes for debarment of a person

(a) Subject to the conditions hereinafter described, the [commission] **Commissioner** may debar a person for any of the following causes.

1. through 12. (No change.)

10:3-1.3 Conditions affecting debarment of a person(s)

(a)-(e) (No change.)

(f) Debarment for the cause set forth in N.J.A.C. [10:31-1.2(a)12] **10:3-1.2(a)12** shall be proper provided that one of the causes set forth in N.J.A.C. 10:3-1.2(a)1 through 11 was the basis for debarment by the original debarring agency. Such debarment may be based entirely on the record of facts obtained by the original debarring agency, or upon a combination of such facts and additional facts.

10:3-2.2 Capital Funding Agreement for Construction, Purchase or Purchase and Renovation of Community-Based Facilities

(a) The Department[al] efforts to consolidate division-specific contracts/agreements has culminated in the development of a Standard Contract/Agreement Document for the Construction, Purchase, or Purchase and Renovation of Community-Based Facilities. Copies of the Standard Document and updates may be obtained from:

[Contract Policy and Management Unit]
**Facilities Support Services**
Department of Human Services
CN 700
Trenton, New Jersey 08625

(b) (No change.)

OFFICE OF ADMINISTRATIVE LAW NOTE: A copy of the Standard Contract/Agreement Document in (a) above was submitted as part of this proposal but is not reproduced herein. This document may be reviewed at the Office of Administrative Law, 9 Quakerbridge Plaza, Trenton, New Jersey 08625 or [the Contract Policy and Management Unit] **Facilities Support Services, CN 700,** 222 South Warren Street, Trenton. This document will not be reproduced in the New Jersey Administrative Code.

10:3-2.3 Capital Funding Agreement for Renovation, Remodeling, Extension or Other Improvements to Agency-Owned or Leased Community Facilities

(a) The Department efforts to consolidate division-specific contracts/agreements has culminated in the development of a Standard Contract/Agreement Document for the Renovation, Remodeling, Extension or Other Improvements to Agency-Owned or Leased Community Facilities. Copies of the Standard Document and updates may be obtained from:

[Contract Policy and Management Unit]
**Facilities Support Services**
Department of Human Services
CN 700
Trenton, New Jersey 08625

(b) (No change.)

OFFICE OF ADMINISTRATIVE LAW NOTE: A copy of the Standard Contract/Agreement Document in (a) above was submitted as part of this proposal but is not reproduced herein. This document may be reviewed at the Office of Administrative Law, 9 Quakerbridge Plaza, Trenton, New Jersey 08625 or [the Contract Policy and Management Unit] **Facilities Support Services, CN 700,** 222 South Warren Street, Trenton. **This document will not be reproduced in the New Jersey Administrative Code.**

10:3-2.4 Capital Funding Agreement for Community-Based Facility Planning and Design Services

(a) The Department, continuing in its efforts to consolidate contracts and agreements, has developed the Funding Agreement for Community-Based Facility Planning and Design Services document to be used by all divisions for preliminary planning/design services. Copies of the standard document and updates may be obtained from:

[Contract Policy and Management Unit]
**Facilities Support Services**
Department of Human Services
CN 700
Trenton, New Jersey 08625

(b) (No change.)

OFFICE OF ADMINISTRATIVE LAW NOTE: A copy of the Standard Contract/Agreement Document in (a) above was submitted as part of this proposal but is not reproduced herein. This document may be reviewed at the Office of Administrative Law, 9 Quakerbridge Plaza, Trenton, New Jersey 08625 or [the Contract Policy and Management Unit] **Facilities Support Services, CN 700,** 222 South Warren Street, Trenton. This document will not be reproduced in the New Jersey Administrative Code.

10:3-3.1 Purpose and scope

This rule applies to all departmental components [and the], County Human Services Advisory Councils (CHSACs) **and designated entities** when departmental components choose to issue an RFP, and to all groups or entities responding to RFPs for contracts for the provision of third-party social services or training. The RFP process, except when the Departmental component chooses to RFP, shall not be required for renewal or expansion of Department purchase of service contracts for programs in effect as of November 4, 1991. In addition, the RFP process shall not apply to renewal of contracts for which an RFP was utilized in selection of the current grant recipients.

10:3-3.2 Definitions

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

. . .

**"Designated entity" means that group or county board which has been given the authority by the Department of Human Services to solicit human service proposals for review and comment and recommended acceptance for third-party social service Contracts. Although the RFP is handled by a group other than the departmental component, the contract is signed and finalized by the departmental component.**

10:3-3.3 Request for proposal

(a) The departmental component or CHSAC/**designated entity** shall issue a public announcement of the availability of funds for the purchase of services in accordance with N.J.S.A. 52:14-34.4, 34.5 and 34.6. The announcement shall be made in a manner to permit reasonable competition among eligible provider agencies. The departmental component shall publish the announcement in the New Jersey Register. In addition, the announcement may be mailed to identified prospective provider agencies[,] **and/or** advertised in at least three newspapers of general circulation[, and/or distributed at bidders' conferences by the departmental component of CHSAC].

**(b) The departmental components may choose to have bidders conferences. Technical information regarding the RFP may be disseminated at such a meeting.**

[(b)]**(c)** The CHSACs/**designated entities**, at minimum, shall use the standards set forth in this subchapter when they are delegated the responsibility to solicit proposals on behalf of the Department. In all other instances, the departmental component shall notify the CHSACs/**designated entity** of the RFP, if appropriate.

[(c)]**(d)** (No change in text.)

[(d)]**(e)** The departmental component or the CHSAC/**designated entity** shall forward a proposal package to or it may be picked up by those prospective applicants responding to the public announcement. In addition, when the CHSACs/**designated entities** have been delegated the responsibility to solicit proposals on behalf of the Department, all appropriate Department procedures, as set forth in this subchapter, and county procedures, **as appropriate,** must be followed. The proposal package shall contain, at minimum, the following information and requirements:

1.-13. (No change.)

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14. A statement explaining the appeals process and that appeals to the departmental component must be completed within the time frame specified in the RFP or within 15 days after receipt of the CHSAC/**designated entity** recommendation, and that appeals to the CHSAC/**designated entity** must be completed within the 90 day [HSAC] process time period and prior to the recommendations being sent to the departmental component.

10:3-3.4 Sole source services

Where there is none or only one response to the RFP, after specifications of the RFP have been cited and all criteria of this subchapter have been met, documentation of any and all efforts to obtain multiple responses shall be kept in the Department RFP file. Documentation shall also be retained of every contact made by the departmental component or CHSAC/**designated entity** to find a provider agency to fulfill the required services.

10:3-3.5 Internal controls for proposals

(a) The departmental component or CHSAC/**designated entity** shall record all correspondence to and from the departmental component or CHSAC/**designated entity**, whichever applicable, in a log retained in the individual program RFP file.

(b) Correspondence shall be recorded in the log by a staff person different from the staff personnel who are on the review panel and [participated] **participating** in the selection process.

(c) The log shall indicate, at a minimum, the following information:

1.-5. (No change.)

6. The name of the Department or CHSAC/**designated entity** staff person receiving the proposal for review and selection;

7.-8. (No change.)

(f) (No change.)

(g) When [the] **a** CHSAC[s]/**designated entity** [are] **is** handling the RFP process, [the final selection(s)] **all documentation** shall be forwarded to the departmental component responsible for signing the contract for final approval and retention. [All other documentation regarding the selection process shall be made available at the CHSAC office for review by the departmental component.]

(h) The departmental component shall communicate to the CHSAC/**designated entity** the outcome of any departmental component appeal on a CHSAC/**designated entity** RFP and forward a copy of the final award letter.

10:3-3.6 Funding proposal program summary and evaluation data; list of required information

(a) The funding proposal requirements shall apply to all proposals submitted to a departmental component or CHSAC/**designated entity**. Each proposal submitted to a departmental component or CHSAC/**designated entity** shall contain the following:

1.-25. (No change.)

10:3-3.7 Composition of review panel

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

(c) The panel may consist of an allocations review panel under the CHSAC/**designated entity** or the following:

1.-11. (No change.)

(d) (No change.)

10:3-3.9 Evaluation of applicant

(a) The applicant shall be evaluated to determine the following (an on-site evaluation may be conducted by the departmental component or CHSAC/**designated entity** if deemed necessary). **The** CHSAC[s]/**designated entity** shall evaluate the applicant on only those factors with which they are familiar or about which they have accurate information. The Department is responsible for evaluation of all information presented by the applicant in the RFP.

1.-9. (No change.)

10:3-3.10 Notification of decision

(a) (No change.)

(b) An appeal based on the determination may be filed according to the procedures established by the departmental component or CHSAC/**designated entity** which shall be referenced in the notice of decision to the applicant.

(c) (No change.)

10:3-3.11 Document retention

[All documentation used to evaluate the responding applicant proposals, as well as any information collected to evaluate the applicant itself, shall be retained by the departmental component or CHSAC for a minimum of 50 days after the date of the notification of decison letter.] **Awarded contracts, signed originals, all support materials and the record copy shall be retained by the departmental component for three years after the termination of the contract and four years thereafter at the records center prior to destruction. Unsuccessful proposals shall be retained for one year by the departmental component and then may be destroyed.** [This] **The material to be retained** includes the RFP, the applicant proposals, all evaluation sheets, and any other documentation which details why the agency was selected or not selected. [If the final decision is not appealed within the specified time frames, the documentation may be destroyed after 50 days. A copy of the approved and funded proposal shall be retained by the departmental component in the contract file.]

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# (a)

## DIVISION OF MENTAL HEALTH AND HOSPITALS

### Interim Assistance Procedures Manual

### Proposed Amendments: N.J.A.C. 10:38-1.4, 2.1, 2.2, 3.3, 3.4, 3.6, 3.8, 4.3, 5.2, 7.2, 7.4, 7.5, Appendices C, E and G

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

Authority: N.J.S.A. 30:4-27.19.

Proposal Number: PRN 1993-66.

Submit comments by September 15, 1993 to:

Raymond M. Deeney, Esq.
Administrative Practice Officer
Division of Mental Health and Hospitals
CN 727
Trenton, NJ 08625-0727

The agency proposal follows:

**Summary**

The New Jersey Department of Human Services, in conjunction with the United States Department of Health and Human Services, developed the Interim Assistance Program to permit a State psychiatric hospital client who is clinically ready for discharge to receive financial assistance for living expenses from the State while waiting for the Social Security Administration (SSA) to process the client's application for Supplemental Security Income (SSI). Prior to the existence of the Interim Assistance Program, SSI-eligible clients would have had to remain hospitalized while awaiting SSA processing of the SSI application or would have had to be discharged with no income for several months.

The Interim Assistance Procedures Manual, N.J.A.C. 10:38, thus became effective July 9, 1981 and was readopted pursuant to Executive Order No. 66(1978) effective May 28, 1986 with amendments effective July 7, 1986. N.J.A.C. 10:38 was then substantially recodified and Subchapter 5, Trial Placement Status, was repealed effective August 6, 1990. Pursuant to Executive Order 66(1978), N.J.A.C. 10:38 was then readopted with amendments effective May 20, 1991.

The amendments at N.J.A.C. 10:38-1.4, 2.1(a)3iv and 2.2 broaden the eligibility standards for the program to include clients who return to either their own or their family home and clients for whom the Social Security Administration has commenced a redetermination process resulting in a suspension of the receipt of benefits by the client. Existing funds have been identified which now permit this beneficial expansion. The Department believes that the availability of program funding will serve as a financial incentive to families of clients who are clinically appropriate to return home. Currently, these clients and families need to wait months before Social Security Administration eligibility and payments are determined and received, resulting in a significant financial burden.

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Amendments at N.J.A.C. 10:38-3.3 and throughout the proposal text have been made to reflect the current practice that a discharge or financial unit or equivalent now provides various functions described in the rules rather than the hospitals' business managers. The amendments at N.J.A.C. 10:38-3.4(a)9 and 10 clarify which hospital staff have these previously unspecified but necessary responsibilities. The amendment at N.J.A.C. 10:38-3.4(b)6, providing that 30 days' notice of the State's intent to terminate the contract for Interim Assistance need not be given to the housing provider when the client is living with his or her parent at home, reflects a provision contained in the current standard contracts between the Division and housing providers and therefore functions as a clarification. The amendments at N.J.A.C. 10:38-3.4(e) reflect the reality that when a client returns to his or her own or family home, the discharge unit or equivalent need not locate a residential placement and that sometimes a drug or alcohol treatment program is a clinically appropriate placement. The amendment at N.J.A.C. 10:38-3.4(f)5 changes the timeliness of the notice requirement regarding the termination of Interim Assistance benefits to be as soon as possible but in no case later than the effective date of termination.

The amendments at N.J.A.C. 10:38-3.6 and 3.8 reflect the reality that when a client returns to his or her own or family home, the hospital business office need not obtain invoices from or make payments to housing providers and contracts with housing providers need not be signed. Amendments at N.J.A.C. 10:38-4.3 clarify that clients are only eligible for the maximum monthly Personal Needs Allowance regardless of the number of days in particular calendar months and Interim Assistance payments to housing providers and clients returning to their own or family home should be at the SSI monthly maintenance rate. Additionally, the amendment at N.J.A.C. 10:38-4.3(e)5 requires housing providers to collect payments directly from clients with other Federal annuity income. The purpose of this amendment is to promote the ability of clients to utilize their own money responsibly.

The amendments at N.J.A.C. 10:38-5.2(a) merely acknowledge within the current procedures that clients may now also be residing in their own or family home while receiving Interim Assistance. The amendment at N.J.A.C. 10:38-7.2(a) clarifies that the hospital business managers are only responsible for recouping Interim Assistance payments from those client's personal funds which are accessible to the managers. Amendments at N.J.A.C. 10:38-7.4 provide that clients receiving Interim Assistance shall send additional Federal income to their provider directly rather than to the hospital business manager and indicate the procedures the hospital business manager must follow if clients do not pay the housing provider directly.

Amendments at N.J.A.C. 10:38-7.5 also establish the requirement of client payments directly to housing providers and clarify that a particular invoice form need not be utilized when a client resides in his or her own or family home. Additionally, an amendment allows the Business Manager's Financial Inquiry form to be mailed to either the client or the housing provider rather than both. The amendment corrects an inappropriate use of the word "and" in the rules currently since the form need only be completed by either the client or the housing provider.

Finally, the Contract for Interim Assistance, the Payee Agreement and the Business Manager's Financial Inquiry in the Appendix have all been amended to reflect the proposed rule amendments summarized above.

**Social Impact**

Fundamental clinical and legal principles require that hospitals discharge clients as soon as clinically appropriate. Many clients, however, lack adequate finances to sustain themselves in the community and a substantial waiting period often occurs between application for and receipt of SSI benefits. The Interim Assistance Program currently advances financial assistance to approximately 140 clients every month. Without this assistance, many clients would remain hospitalized longer than necessary or be discharged without income. This would constitute an inappropriate delay and/or jeopardize the client's ability to resume a normal life in the community. Thus, the Interim Assistance Program provides a positive social impact to many clients by enabling them to take advantage of clinically appropriate placement opportunities. When clients are appropriately placed in less costly and less restrictive settings, the Department also benefits by being able to more effectively utilize its limited hospital resources and the public benefits from the more normalized social functioning of the discharged clients. Also, requiring clients with income to pay providers directly is likely to enhance their ability to utilize their money responsibly.

Specifically, these amendments will positively affect State psychiatric hospital patients by making more of them eligible for Interim Assistance payments, namely those with an opportunity to return to their own family home but in need of interim financial assistance and those subject to Social Security Administration redeterminations. Moreover, the Department believes clients will also be more likely to develop skills of financial responsibility by paying their housing providers directly.

Specifically, these amendments will positively affect housing providers by having them receive some payments directly from clients, thus providing them with income sooner than they now receive it.

**Economic Impact**

Expansion of the Interim Assistance Program will reduce costs by facilitating clinically appropriate client discharges from more expensive State psychiatric hospitals into less expensive community settings.

Allowing providers to collect directly from clients with other income will improve their cash flow by reducing their wait to receive payments, thus promoting their financial viability. Capping payment rates at 30 days per month will further reduce hospital labor costs by making the payment methodology more uniform and efficient and will track the Federal payment methodology.

**Regulatory Flexibility Analysis**

The proposed amendments impose certain reporting, recordkeeping and other compliance requirements on agencies under contract with the Division of Mental Health and Hospitals to provide residential services to clients needing these services. Many of these agencies may be considered small businesses as defined by the Regulatory Flexibility Act because they employ less than 100 full time employees (see N.J.S.A. 52:14B-16 et seq.).

The proposed amendments establish compliance requirements for agencies providing residential services to Interim Assistance Program clients. N.J.A.C. 10:38-3.8(a)1 through 8 establish specific reporting, recordkeeping and compliance requirements for these provider agencies, including the requirement to notify the hospital which has placed a client with them in certain circumstances and also to refund payments to that hospital in certain circumstances. Although these proposed amendments do not require housing providers to maintain a record if and when they receive payments of other Federal income from clients, the effect of this amended practice would seem to require it so that the additional amount due from the Interim Assistance Program could be confirmed.

No capital costs are associated with these requirements and no additional professional services will be needed for compliance. Compliance requirements are necessary and standards are uniformly applied regardless of the size of the provider agencies in order to assure the safety and well-being of the clients involved and the financial integrity of the Interim Assistance Program.

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

10:38-1.4 Definitions

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

. . .

**"Redetermination" means a process whereby the Social Security Administration annually reviews SSI recipients to evaluate continuing eligibility. The process may also involve recipients who are in an institution less than one year or who have been discharged from an institution in which they were hospitalized for less than one year.**

. . .

10:38-2.1 Clients eligible for Interim Assistance

(a) To be determined eligible for Interim Assistance (IA), a client shall:

1.-2. (No change.)

3. Have been evaluated by the Interdisciplinary Treatment Team as ready for release to one of the following:

i. Residential health care facility;

ii. Boarding home;

iii. Residential drug or alcohol rehabilitation program;

iv. **His or her own home, family or Division of Mental Health and Hospitals contract agency;**

[iv.]**v.** Rooming house; or

[v.]**vi.** Transitional residence; and

4. (No change.)

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10:38-2.2 Clients ineligible for Interim Assistance

(a) A client in a State psychiatric hospital is not eligible for Interim Assistance when any of the following conditions exists:

1.-2. (No change.)

3. The client is under 18 years of age; **or**

[4. The client is returning to his or her own home or family; or]

[5.]**4.** The client is on the active SSI rolls (receiving a monthly Federal PNA stipend) **and SSA has not commenced a Redetermination process.**

10:38-3.3 The hospital social service staff or designee

(a) The Discharge Oriented Service Plan shall establish the client's need for assistance in financial planning and placement needs. If such a financial need is evident and the client appears to meet Interim Assistance eligibility criteria, the hospital social service staff or designee shall:

1.-5. (No change.)

6. Once notified by the [business manager] **Discharge or Financial Unit or equivalent** that the retroactive SSI check is received and Interim Assistance has been terminated, ensure that the client's discharge is recorded properly on the hospital's daily population movement report and that all appropriate hospital staff are notified of discharge; and

7. (No change.)

10:38-3.4 Responsibilities of the Discharge and/or Financial Unit

(a) The Discharge or Financial Unit **or equivalent** shall play a major role in several areas, specifically:

1.-6. (No change.)

7. Assist clients in filing and processing appeals; [and]

8. (No change.)

**9. Notify the Social Security Administration of any change in the client's living arrangement, such as a return to the hospital or an elopement from the home; and**

**10. Notify the social services staff that the retroactive check is received and Interim Assistance has been terminated.**

(b) The Discharge or Financial Unit **or equivalent** shall maintain a record of each referral received and processed. This record shall contain the dates when:

1.-5. (No change.)

6. [Give the] **The** housing provider **is given** 30 days' notice of the State's intent to terminate the Contract for Interim Assistance. This requirement does not apply **when the client is living with his or her parent at home,** when issues of life/safety or client welfare are involved, or when the resident leaves the home of his or her own accord;

7.-9. (No change.)

(c) The Financial Entitlement Unit **or equivalent** shall, within five working days of receipt of a referral:

1. Submit an initial inquiry to the Social Security Administration to verify social security numbers and to determine if the client is already a recipient of SSI. (If clients are already on the active rolls of SSI **and are not subject to the redetermination process** they are not in need of the Interim Assistance Program);

2.-3. (No change.)

(d) The Financial Entitlement Unit **or equivalent** shall, for a client assessed as eligible for Interim Assistance:

1.-6. (No change.)

(e) The Discharge Unit **or equivalent** shall:

1. [Locate] **If the client is not returning to his or her own home or family, locate** an available, affordable and suitable approved residential facility **or drug or alcohol treatment program** for the client. Such facility shall be licensed and/or under contract to either the Division of Mental Health and Hospitals, the Division of Developmental Disabilities, the Department of Community Affairs, or the Department of Health, as appropriate;

2. [The] **If the client is not returning to his or her own home or family, the** placement social worker shall visit the selected site with the client and, if the client finds it acceptable;

i.-iii. (No change.)

(f) The [financial coordinator] **Financial Coordinator or equivalent** shall:

1.-4. (No change.)

5. Notify the client and the hospital business manager in writing when Interim Assistance payments are **being** terminated **as soon as possible but in no case later than the effective date of termination**; and

6. (No change.)

(g) For a client who has been found eligible for Interim Assistance and is subsequently denied SSI benefits, the Financial Entitlement Unit **or equivalent** shall:

1. If the client files an appeal with the Social Security Administration, continue Interim Assistance payments upon authorization by the Financial Coordinator **or equivalent** during the period of the SSI reconsideration and the hearing at the Administrative Law level;

2.-7. (No change.)

(h) The Financial Entitlement Unit **or equivalent** shall, for a client assessed as ineligible for Interim Assistance:

1.-4. (No change.)

10:38-3.6 Responsibilities of the hospital business office

(a) The hospital business office shall be responsible for all fiscal matters relating to the Interim Assistance Program other than those described in previous and succeeding sections. Business office staff's specific responsibilities shall be to:

1.-5. (No change.)

6. [Obtain] **If the client is placed with a housing provider other than his or her own family or home, obtain** a completed monthly invoice (Appendix F) from the housing provider for maintenance costs;

7. [Make] **If the client is placed with a housing provider other than his or her own family or home, make** monthly payments to the housing provider for validated billings in accordance with procedures described in N.J.A.C. 10:38-4.3;

8. Receive a client's initial retroactive SSI check from the Office of Fiscal and Management Operations, deposit it into the client's account and notify the Financial Entitlement Unit **or equivalent** that the check has been received;

9.-15. (No change.)

10:38-3.8 Responsibilities of the congregate housing provider

(a) [The] **If the client is placed with a housing provider other than his or her own family or home, the** congregate housing provider shall sign a contract for Interim Assistance agreeing to:

1.-8. (No change.)

10:38-4.3 Business office payment procedures

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

(d) The business manager, or his or her designee, shall mail Personal Needs Allowance checks at the per diem rate [and covering a full] **for no more than a 30-day** calendar month, to the client at the community placement address no later than the first working day of each month.

(e) The client's Interim Assistance maintenance payment shall be calculated and disbursed as follows:

1. [At] **If the client is placed with a housing provider other than his or her own family or home, at** the end of each month[,] the business manager shall obtain a completed invoice, form AR 50/54, from the housing provider;

2. (No change.)

3. Validated payments to the housing provider from the Interim Assistance account shall be processed by the 10th calendar day of the following month at the established **monthly SSI rate for** maintenance [rate]. This is a per diem rate based on the current SSI payment[.]**;**

**4. If the client is placed within his or her own family or home, payment shall be made at the established monthly SSI rate for maintenance for a 30-day month; and**

**5. If the client has other Federal annuity income, the housing provider shall collect payments directly from the client. If so, this shall be noted on the invoice. The hospital shall reduce its payment to the provider accordingly.**

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10:38-5.2 Procedures

(a) To ensure continued institutional Medicaid coverage for an Interim Assistance client, the following procedures shall be followed:

1. (No change.)

2. Form FD-34, Medicaid validation, shall be completed by the designated hospital representative on the date of placement and on the first of each month thereafter. The representative shall forward the form to the **client's residence or** appropriate congregate facility [including, but not limited to, boarding homes and group homes]; and

3. The **client, family or** housing provider may use the FD-34, Medicaid validation, to obtain medical care for the client.

10:38-7.2 Responsibilities of the hospital business manager

(a) The hospital business manager shall be responsible for recouping Interim Assistance payments made, first from the client's retroactive SSI check, then from [any of] the client's personal funds**, when accessible,** and finally from the client's other resources.

(b) (No change.)

10:38-7.4 Client or non-institutional agent as payee for available client income

[(a) When an Interim Assistance client receives or has available income directed to a payee other than the Chief Executive Officer of the hospital, the business manager shall bill the client and/or the payee on a monthly basis or at the end of placement, in accordance with the Payee Agreement.]

[(b)]**(a)** The Business Manager's Financial Inquiry form (Appendix G) shall be mailed to the client, the housing provider or outside payee at the end of each month that the client is eligible for and receives Interim Assistance payments. [Invoice] **Unless the client is residing within his or her own family or home, invoice** form AR 50/54 for next month's payment shall be attached to the Financial Inquiry form sent to the housing provider.

[(c)]**(b)** When the Financial Inquiry form is returned to the hospital business manager showing additional Federal annuity income, the business manager shall direct the client and/or payee in writing to make payments from the additional income [to the hospital] **directly to the housing provider in accordance with the Payee Agreement. Should the client or payee refuse to pay the provider directly, the business manager shall calculate and disburse the proper maintenance payment in accordance with N.J.A.C. 10:38-4.3(e). The business manager shall further initiate the steps indicated in N.J.A.C. 10:38-7.6 and 7.7.**

10:38-7.5 Client or non-institutional agent as payee for anticipated income

(a) When an Interim Assistance client or representative payee has not begun to receive anticipated other income payments, the Business Manager's Financial Inquiry form shall be mailed to the client [and] **or** to the housing provider at the end of each month that the client is eligible for and receives Interim Assistance payments. [Invoice] **Unless the client is residing within his or her own family or home, invoice** form AR 50/54 for next month's payment shall be attached to the inquiry form sent to the housing provider.

(b) When the Financial Inquiry form indicating available income is returned to the business manager, he or she shall direct the client to make payments [to the hospital] **directly to the housing provider** in accordance with the Payee Agreement.

APPENDIX C

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
Division of Mental Health and Hospitals

CONTRACT FOR INTERIM ASSISTANCE

THIS AGREEMENT made on this _____ day of _____ in the year _____

WITNESSETH, that I, _____ the undersigned, for and in consideration of payments to be made to me as provided herein, do hereby covenant and agree as follows:

1. I AGREE to accept into my home _____ from the _____ (Hospital Name) and agree to furnish said individual with food, lodging, and other usual and necessary incidentals for the proper maintenance of the said individual and his or her well being.

2. I AGREE to accept the sum of $_____ [(Rate)] per day ($_____ **per month**) from the _____ (Hospital) at _____ (Location) as [full] compensation for maintenance that I shall furnish the said individual. I further understand that the above agreed upon daily compensation rate is established at rates determined by the Social Security Administration in conjunction with the Commissioner of the Department of Human Services and is payable after the services have been provided. **Individuals with other income shall make payments directly to the housing provider.**

3. I AGREE to immediately contact the _____ (Designated Emergency Screening Service) by telephone in the event of need for emergency medical or psychiatric care, notifying them of the full details of the said individual's condition and to abide by such directions as shall be given. In the event of serious emergency medical or psychiatric care, I will contact the _____ (Designated Emergency Screening Service) immediately by telephone after care has been given notifying them of the full details.

4. I AGREE to give the _____ [(Designated Emergency Screening Services)] (Hospital) at _____ (Location) thirty (30) calendar days notice in writing of my intention to terminate this contract; otherwise it shall continue in full force and effect as long as the said individual is under my care, or is subject to termination notice if standards are not maintained.

IN WITNESS WHEREOF, I hereunto set my hand the year and day first written above.

_____
(Signature of Home Operator and/or Responsible Family Member)

Signed and delivered
in the presence of

_____
Witness

CERTIFICATION NOTE:

An Interim Assistance Payee is not entitled to receive dual payments for care provided. A sponsor must[,] therefore: (1) notify the hospital upon learning that a resident received his or her first SSI or other payment and also provide the effective date of such payment; (2) refund the hospital the amount of Interim Assistance payments received after the first SSI or other payment is received if such payment represents duplicate compensation; (3) refund the hospital the amount of Interim Assistance funds from the retroactive SSI payment, which represents a duplicate payment to me for the time period from SSI application to receipt of funds; and (4) notify the hospital immediately should the client terminate residence at the home.

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APPENDIX E

PAYEE AGREEMENT

I understand that I, as an Interim Assistance recipient, will have my community maintenance paid in full **or part** by the Division of Mental Health and Hospitals until a determination of my SSI claim is made. The Division will also supplement my personal needs expenses, when necessary.

I also understand that income available to me or my representative payee while I am an Interim Assistance recipient [must be forwarded as received to the Business Manager,
Psychiatric Hospital, as partial reimbursement of Interim Assistance expenditures], **up to the normal monthly room and board rate, must be turned over to** _____ **toward payment of room and board expenditures.**
(Housing Provider)

I therefore agree:

1. To notify the Business Manager, Psychiatric Hospital, when income or resources from any source becomes available to me or my representative payee; and
2. To [send] **turn over** all income or resources received by me (but not exceeding my [Interim Assistance indebtedness] **monthly room and board rate**) to the [Business Manager,] _____ (Housing Provider) [Psychiatric Hospital], until [Interim Assistance is terminated] **recurring SSI is available**.
3. That, if there are insufficient **recoverable** funds available from the initial SSI retroactive check for full reimbursement of Interim Assistance funds granted, the balance owing may be recovered by the hospital business office from other sources of funds available to me.

In the event that a representative payee selected by me fails to abide by the terms of this agreement, I will take the necessary steps to have a new representative payee appointed.

Witness: _____ Signature: _____

Address: _____

Date: _____

I, _____, agree to the terms stated above and will send, when billed, all funds received by me on behalf of _____ (client) to the Business Manager, _____ Psychiatric Hospital.

I understand that these funds will be used as partial reimbursement for Interim Assistance granted to _____ (client). This agreement will remain in effect until such time as I am notified by the Business Manager, _____ Psychiatric Hospital, to redirect these payments.

Witness: _____ Signature: _____

Address: _____

Date: _____

Sample Form
Distribution:

Business Manager—original
Client
Representative Payee
Financial Coordinator

APPENDIX G

BUSINESS MANAGER'S FINANCIAL INQUIRY

[re] **Re:** _____ [*(Client)*]
(Client)

Dear _____:
(Housing Provider)

Please respond to the following questions and return [this form] to me within 5 days of receipt.

Has the above named client received:

| | YES | NO |
|---|---|---|
| Supplemental Security Income Payment? | ☐ | ☐ |
| A Social Security benefit? | ☐ | ☐ |
| Any other type of payment *(specify)* _____ | ☐ | ☐ |

If your answer is "yes" to any of these questions, please provide the following information:

Date Payment was received _____

Type of Payment _____

Amount of Check(s) _____

Check(s) issued to **(name)** _____

_____
**Business Manager**

_____
**Housing Provider**

_____
**Client**

Sample Form
Distribution:

**Housing Provider—Original**
Client[—Original]
[Housing Provider]
Business Manager

## (a)

## DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

### Lifeline Credit Program/Tenants' Lifeline Assistance Program Manual

### Proposed Readoption with Amendments: N.J.A.C. 10:69B

Authorized By: William Waldman, Commissioner, Department of Human Services.
Authority: N.J.S.A. 48:2-29.15 et seq. and 48:2-29.31 et seq.
Agency Control Number: 93-P-9.
Proposal Number: PRN 1993-425.

Submit comments by September 15, 1993 to:
Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
CN-712
Trenton, NJ 08625-0712

The agency proposal follows:

**Summary**

The purpose of this proposal is to readopt the existing rules known as the Lifeline Credit Program/Tenants Lifeline Assistance Program Manual. The current text of this chapter is scheduled to expire on November 21, 1993, pursuant to Executive Order No. 66(1978), commonly known as the "Sunset" Executive Order. The Division of Medical

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Assistance and Health Services has reviewed the existing rules and found them to be necessary, adequate, reasonable, efficient and responsive for the purpose for which they were promulgated. The rules establish eligibility procedures and standards, describe the method of payment of the Lifeline benefit, set forth the administrative organization, and explain the procedures for recoveries of benefits incorrectly paid. Therefore, the rules should be continued.

The chapter was last readopted in 1988, effective November 21, 1988. Since that time, the rule has been amended twice. In 1991, income eligibility was revised upwards, from $13,650 for a single person to $15,700, and from $16,750 for a couple to $19,250. See 23 N.J.R. 2623(a) and 23 N.J.R. 3514(a). In 1992, the rule was amended to extend the filing deadline from January 31 to March 15. See 23 N.J.R. 3267(a) and 24 N.J.R. 466(a). One further amendment to the rule was proposed in the August 2, 1993 New Jersey Register: income eligibility is being increased from $15,700 to $16,171 for single persons, and from $19,250 to $19,828 for couples, in accordance with P.L. 1993, c.3. The law increased the income levels effective January 1, 1993.

The New Jersey Lifeline Credit Program (LCP) was established by P.L. 1979, c.197, as amended and supplemented, and codified as N.J.S.A. 48:2-29.15 et seq. The New Jersey Tenants Lifeline Assistance Program (TLAP) was established by P.L. 1981, c.210, as it amends and supplements P.L. 1979, c.197, which was codified as N.J.S.A. 48:2-29.31 et seq.

The laws cited above provide that both utility customers and tenants whose utility costs are included in their rent can qualify for the Lifeline benefit, which is currently $225.00, annually. Utility customers who qualify for the Lifeline Credit Program receive a credit of $225.00 toward their utility costs. Tenants who qualify under TLAP receive a check for $225.00, annually. Persons who are eligible for SSI (Supplemental Security Income) receive an additional State Supplement in their monthly SSI check. The new income levels are applicable to eligible utility customers and tenants.

There are some amendments associated with this readoption. The amendments are being made to Subchapters 1 and 2.

In Subchapter 1, at N.J.A.C. 10:69B-1.3, Definitions, the name of the Board of Public Utilities is being changed to Board of Regulatory Commissioners, both in reference to the electric utility and the gas utility. Due to the Board's reorganization, the Division needs to change the name to comply with Executive Order No. 38, signed by Governor Jim Florio on August 14, 1991. A second change in the subchapter, at N.J.A.C. 10:69B-1.4, Lifeline Credit/Tenants Lifeline Assistance payment, concludes the sentences in N.J.A.C. 10:69B-1.4(a)3iv and at 10:69B-1.4(c)1ii with "Treasurer, State of New Jersey," and removes the specification as to the disposition the Treasurer will make of the unused balance remaining in a terminated beneficiary's account. This change in the disposition of unused Lifeline Assistance payments is necessitated by changes in the funding of the Lifeline Assistance programs.

In Subchapter 2, at N.J.A.C. 10:69B-2.5(b), Responsibilities of the utility companies, the word "and" is being inserted between "electric" and "gas."

**Social Impact**

The Lifeline Programs provide financial relief to approximately 287,000 households from increased utility costs during the winter months.

The proposed readoption impacts directly on public utility companies, who are already performing administrative functions, such as confirming customer status and issuing credits.

The rules should be continued, so that persons who are eligible for the Lifeline programs can continue to receive this benefit.

**Economic Impact**

Persons who qualify for Lifeline will continue to receive $225.00. For utility customers, this amount will be applied as a credit against their utility bills. Tenants whose utilities are included in their rent will receive a lump sum check. SSI recipients will receive a special utility supplement in their monthly SSI check. Under N.J.A.C. 10:69B-2.5, electric and gas utility companies perform certain administrative functions related to the program.

The cost of the Lifeline Programs was approximately $66,926,000 in State Fiscal Year 1992. The Lifeline Programs are completely State funded. Appropriations have been made annually since the program's inception.

**Regulatory Flexibility Statement**

The Division does not believe a regulatory flexibility analysis is required. Eligibility determinations are made by the Bureau of Lifeline Credit Programs within the Division of Medical Assistance and Health Services. The public utility companies also perform administrative functions. Neither the State nor the utility companies could be considered as "small businesses" as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

**Full text** of the proposed readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:69B.

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

10:69B-1.3 Definitions

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

. . .

"Electric utility" means every New Jersey public utility which provides residential electric service, as defined in this section, and is regulated by and subject to the jurisdiction of the Board of [Public Utilities] **Regulatory Commissioners**. Additionally, any municipality or other governmental entity providing residential electric service, as defined in this section, within the State of New Jersey, shall be deemed an electric utility for the limited purposes of this program.

"Gas utility" means every New Jersey public utility which provides residential gas service, as defined in this section, and is regulated by and subject to the jurisdiction of the Board of [Public Utilities] **Regulatory Commissioners**. Additionally, any municipality or other governmental entity providing residential gas service, as defined in this section, within the State of New Jersey, shall be deemed a gas utility for the limited purposes of this program.

. . .

10:69B-1.4 Lifeline Credit/Tenant's Lifeline Assistance payment

(a) The Lifeline Credit shall consist of a single amount established by law, which will be applied, on a yearly basis, to the electric and/or gas utility bills of an eligible residential customer. Only one credit per year is allowed per household, regardless of the number of eligible residential utility customers living in that household.

1.-2. (No change.)

3. When an eligible residential utility customer terminates service, the unused balance of the Lifeline Credit shall be dispersed accordingly.

i.-iii. (No change.)

iv. The electric and/or gas utility shall return within 60 days of termination of service, any unused balance that cannot be transferred as stated in N.J.A.C. 10:69B-1.4(a)3i, ii, iii, to the Treasurer, State of New Jersey[, who will redeposit the nontransferable credits in the Casino Revenue Fund].

(b) (No change.)

(c) A Special Utility Supplement has been established to assist Supplemental Security Income (SSI) beneficiaries who are not eligible for Lifeline Credit or Tenants Lifeline Assistance. This yearly supplement amount, established by law in lieu of Lifeline Credit or Tenants Lifeline Assistance, will be added to each monthly SSI check in an amount equal to 1/12 of the yearly supplement.

1. When an SSI beneficiary is no longer eligible for the SSI Program, any remaining balance of the Special Utility Supplement shall be dispersed accordingly.

i. (No change.)

ii. If the terminated SSI beneficiary is not eligible for Lifeline Credit or Tenants Lifeline Assistance, the remaining balance of the Special Utility Supplement shall be returned to the Treasurer, State of New Jersey[, and redeposited in the Casino Revenue Fund].

10:69B-2.5 Responsibilities of the utility companies

(a) (No change.)

(b) Each electric **and** gas utility shall apply only one credit per utility account of an eligible residential utility customer.

(c)-(f) (No change.)

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# (a)

## DIVISION OF YOUTH AND FAMILY SERVICES

## Manual of Requirements for Family Day Care Registration

## Proposed Readoption: N.J.A.C. 10:126

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

Authority: N.J.S.A. 30:5B-16 et seq., specifically 30:5B-19, 23 and 25.

Proposal Number: PRN 1993-421.

Submit comments in writing by September 15, 1993 to:
Richard Crane, Acting Chief
Bureau of Licensing
Division of Youth and Family Services
CN 717
Trenton, New Jersey 08625-0717

The agency proposal follows:

### Summary

The Division of Youth and Family Services in the Department of Human Services is authorized to adopt regulations and to regulate family day care sponsoring organizations and voluntarily registered family day care providers in New Jersey pursuant to N.J.S.A. 30:5B-16 et seq. The Division's Manual of Requirements for Family Day Care Registration (N.J.A.C. 10:126) constitutes regulations that govern 15 family day care sponsoring organizations and some 4,000 voluntarily registered family day care homes throughout New Jersey. These regulations expire on November 7, 1993, in keeping with the "sunset" provisions of Executive Order No. 66 (1978) governing administrative regulations. The Division proposes to readopt this chapter without change.

The New Jersey Family Day Care Provider Registration Law (N.J.S.A. 30:5B-16 et seq.) established a two-tiered system of voluntary regulation for family day care providers, who provide child care for up to five children in the provider's private residence. Under the Law, family day care providers are not required to register; but if they choose to register, they must comply with State requirements. The Division of Youth and Family Services inspects, approves and contracts with selected family day care sponsoring organizations to carry out the voluntary registration system in specific geographic areas (which may include one or more counties). In turn, each sponsoring organization is responsible for inspecting, registering and monitoring family day care providers to ensure their compliance with State regulations, and for providing technical assistance, training and consultation to providers to assist them in maintaining compliance.

The chapter includes: general provisions, such as definitions and approval requirements for sponsoring organizations; sponsoring organization administrative requirements; staff and service requirements for sponsoring organizations; provider registration and operation procedures; and safety, health and program requirements for providers.

This chapter originally became effective on November 7, 1988 and has not been amended. The Division plans to propose amendments in the near future to update, strengthen, clarify and improve the current rules to reflect the changing needs of family day care providers, parents of children attending family day care, and family day care sponsoring organizations. In addition, the Division plans to propose amendments required as a result of recently enacted legislation (N.J.S.A. 40:55D-66.5a et seq., commonly known as the family day care zoning law, as amended by P.L. 1992, c.13), which necessitates changes in some of the manual's existing rules as well as the development of new rules.

When originally enacted on September 13, 1991, the zoning law required registered family day care providers and other adults living or working in the home to undergo and pay for Criminal History Record Information (CHRI) fingerprint background checks. P.L. 1992, c.13, which was signed into law on May 28, 1992, postponed until December 1, 1993 the implementation of the CHRI requirements. Since the law was amended, child care advocacy groups have been working to develop proposed alternatives to the CHRI requirements in an effort to reduce the economic burden of the fees associated with obtaining fingerprints and processing the CHRIs, which often exceeded $100.00 per home. The Division realized that any amendments to the manual that may become necessary to implement the CHRIs could not be drafted until after the current rules expire. While amendments to other areas of the manual could have been proposed before any amendments related to CHRIs, this approach would have been likely to cause confusion by creating two proposals and two adoptions for the same rules in the same year. Instead, the Division chose to delay proposing any amendments until the CHRI-related issues are resolved, so that only one proposal and adoption will be needed. To ensure that rules governing the registration program remain in effect without lapses, the Division proposes to readopt the current rules now, anticipating that the readoption will become final before the current rules expire, and that amendments will be proposed at a later date.

### Social Impact

The readoption of this chapter will have a positive social impact by permitting the continued operation of some 4,000 voluntarily registered family day care homes, and 15 family day care sponsoring organizations that are contracted to assist the Division in carrying out the registration program.

Under these rules, providers have access to training and support through their sponsoring organization, enabling them to improve their services to children. Registration entitles providers to participate in State programs providing parent referrals and reimbursement for food expenses, and helps providers attract parents seeking safe, acceptable and reliable child care.

Parents are assured that a registered provider has met State requirements and is subject to periodic monitoring. Registered providers are required to communicate with parents regularly and to discuss their child's needs and daily routines. Parents can also be reassured that physical punishment is not permitted in a registered home; positive methods of discipline are used to help children learn appropriate behavior. Parents are able to contact the sponsoring organization for assistance if they have any questions or need special help for their children.

The sponsoring organizations and other child care organizations, as well as many providers, have been informed of the Division's plans to readopt the manual at this time and to propose amendments in the near future. In fact, representatives of these groups have participated in a special Citizens Ad Hoc Advisory Committee convened by the Division to review and discuss the amendments that will be proposed later on. The Committee is aware of the above-cited legislation that delayed implementation of the provisions for CHRI fingerprint background checks, and will be invited to participate in the development of amendments to the manual to implement the CHRI process if necessary. The Committee fully supports the readoption of the manual at this time as a means to ensure the continued operation of the registration program, while the Division continues to work in cooperation with the child care community on revisions to the rules to be proposed in the near future.

### Economic Impact

The proposed readoption will have a positive economic impact by permitting the registration program to continue operating. The family day care sponsoring organizations will continue to be able to use Division funds to register new providers and maintain services to already-registered providers. Registered providers will be able to keep their Certificates of Registration in effect without interruption, so that they can continue to receive the benefits of registration, including free training and technical assistance, eligibility for the Federal Child Care Food Program, easier access to liability insurance, contacts with parent-consumers through the State Child Care Resource and Referral System, and exemption from local municipal zoning restrictions that may otherwise apply to home-based businesses.

### Regulatory Flexibility Analysis

This proposed readoption will affect 15 family day care sponsoring organizations and some 4,000 registered family day care homes, all of which fall within the definition of a small business, as defined in the State Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. It is not appropriate or necessary to establish differential rules that would apply to larger or smaller entities, as all regulated entities are considered small businesses. The readoption continues the existing rules that have been in effect since 1988 and that establish minimum baseline requirements for sponsoring organizations that have been selected through the State bidding process, and for family day care providers who have chosen to become registered. Since participation in the registration program by both sponsoring organizations and providers is voluntary, the readoption will only affect a limited number of small businesses that have agreed to comply with the requirements of this chapter. Also, it should be emphasized that rules governing family day care homes were designed

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to accommodate the small, homelike settings of these child care arrangements, with every effort made to avoid regulations that would deviate from the home atmosphere or that would impose economic hardships on these providers.

The current rules establish the requirements for approval of sponsoring organizations. An approved sponsoring organization is required to report to the Division: child abuse/neglect; imminent danger to child health and safety in a provider's home; injury to a child requiring a hospital visit, or the death of a child, while in a provider's care; registration-impairing office damage or the closing of the organization; criminal convictions of organization staff, a provider substitute, or a member of a provider's household; cancellation of the organization's liability insurance coverage; and changes to the organization's name, location, executive director or administrator. Sponsoring organizations must report reportable diseases to the local health department of a provider's municipality. Sponsoring organizations are required to maintain comprehensive administrative, provider and statistical records, and to report statistical data to the Bureau of Licensing upon request. Record access and confidentiality requirements are established. Sponsoring organizations' staff requirements are imposed concerning staff types, responsibilities, qualifications and training. Sponsoring organizations are required to evaluate, train, register, monitor and provide technical assistance to providers, to investigate and remedy complaints against providers, and to provide specific information to parents.

Eligibility and application requirements for providers seeking registration are established. Providers are required to report to the Division child abuse/neglect, and to report to the sponsoring organization injury to a child requiring a hospital visit, or the death of a child, while in a provider's care; damage to a provider's home affecting chapter compliance; criminal conviction of a provider, provider's assistant, provider substitute or a member of the provider's household; occurrence of reportable disease; or termination of service. Providers are required to maintain on file a signed receipt from each parent for the Information to Parents statement, and to maintain an individual record for each child containing specified information. Safety, health and program requirements for providers are imposed in the following areas: maximum number of children; physical environment; fire safety; general safety; outdoor space; transportation; health examinations for children; sick children; child accident and injury; handwashing; activities for children; rest and sleep; food and nutrition; feeding management for children under 1½ years of age; toilet training; care of school-age children; special needs children; supervision; guidance and discipline; and communicating with parents.

As stated at the beginning of this analysis, the rules are designed to preserve the providers' home atmosphere and avoid imposing economic hardship. Providers will incur some varying expense in maintaining compliance. The Department does not expect that sponsoring organizations or providers will find it necessary to employ any special professional services to comply with the rules.

**Full text** of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:126.

# LAW AND PUBLIC SAFETY

## (a)

## DIVISION OF CONSUMER AFFAIRS
## STATE BOARD OF ARCHITECTS
### Fees
### Proposed Amendment: N.J.A.C. 13:27-5.8

Authorized By: State Board of Architects, Charles A. Spitz, President.

Authority: N.J.S.A. 45:3-3 and 7 and 45:1-3.2.

Proposal Number: PRN 1993-426.

Submit written comments by September 15, 1993 to:
Kevin Earle, Executive Director
State Board of Architects
Post Office Box 45001
Newark, New Jersey 07101

The agency proposal follows:

**Summary**

The proposed amendment to N.J.A.C. 13:27-5.8(b) revises the graphic and written examination fees so that they will always total the amount charged the State Board of Architects by the National Council of Architectural Registration Boards (NCARB), plus an additional fee of $25.00 for the graphic portion and an additional fee of $15.00 for the written portion so as to cover the State Board's own administrative costs for handling the exam. As of this time, the next proposed increases from NCARB are scheduled to be effective June 1994.

**Social Impact**

The proposed amendment will impact only those applicants who, as part of the licensure process, must sit for the graphic and written portions of the architectural examination. The licensing process itself enables only qualified individuals to service the public, thus protecting health and welfare.

**Economic Impact**

The State Board of Architects has been advised of a schedule of increases in the graphic and written portions of the examination fee by the test administrators. The proposed amendment to the Board is required to cover these expenses. Individuals seeking licensure will be affected by this increase.

**Regulatory Flexibility Statement**

The proposed amendment to the State Board of Architects fee schedule will affect only individual applicants; no regulatory flexibility analysis is, therefore, necessary.

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

13:27-5.8 Fees

(a) (No change.)

(b) The fees for the licensing examination **and any reexamination** are as follows:

[1. Entire Architectural Registration Examination—$545.00;

i. Division A: Pre-Design $55.00;

ii. Division B: Site Design, Graphic $85.00; Site Design, Written $40.00;

iii. Division C: Building Design, $115.00;

iv. Division D/F: Structural General and Long Span $50.00;

v. Division E: Structural Lateral Forces $35.00;

vi. Division G: Mechanical, Plumbing, Electrical and Life Safety Systems $55.00;

vii. Division H: Materials and Methods $55.00;

viii. Division I: Construction Documents and Services $55.00;

ix. The fee for retake of any part of the exam is the same as listed above.]

**1. Graphic: the fee charged the Board by the National Council of Architectural Registration (NCARB), plus $25.00;**

**2. Written: the fee charged the Board by NCARB, plus $15.00.**

(c)-(e) (No change.)

## (b)

## DIVISION OF CONSUMER AFFAIRS
## STATE BOARD OF NURSING
### Notice of Public Hearing
### Homemaker-Home Health Aide Competency Evaluation
### Proposed New Rules: N.J.A.C. 13:37-14.

**Take notice** that on June 4, 1993, on behalf of the Assembly Health and Human Services Committee, Garabed "Chuck" Haytaian, Speaker of the New Jersey General Assembly, requested the Board to schedule a public hearing regarding proposed regulations for the certification of homemaker-home health aides as published in the May 17, 1993 issue of the New Jersey Register at 24 N.J.R. 1950(a).

Accordingly, pursuant to N.J.S.A. 52:14B-4(a)3, the Board will hold a **public hearing** on Wednesday, September 15, 1993 at the War

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Memorial Building, West Lafayette Street, Trenton, New Jersey between 10:00 A.M. and 12:00 P.M.

The intent of the public hearing is to afford all interested parties an opportunity to present testimony to the Board on the issue of the homemaker-home health aide competency examination; specifically, whether homemaker-home health aides should be certified by a centralized State examination or by a competency evaluation which is part of the training process at the agency level.

Those interested in providing testimony at the public hearing should advise the Board in writing of their intent to do so by September 8, 1993 at the following address:

Sister Teresa Harris, Executive Director
State Board of Nursing
P.O. Box 45010
Newark, New Jersey 07101

# (a)

## NEW JERSEY RACING COMMISSION

### Harness Rules
### The Pick(N)
### Proposed New Rule: N.J.A.C. 13:71-27.56

Authorized By: New Jersey Racing Commission, Frank Zanzuccki, Executive Director.
Authority: N.J.S.A. 5:5-30.
Proposal Number: PRN 1993-459.

Submit written comments by September 15, 1993 to:
Mike Vukcevich, Deputy Director
New Jersey Racing Commission
CN 088
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

On July 3, 1992, New Jersey racetracks began the simulcasting of full race cards from other states. These race cards included many exotic type wagers not permitted at New Jersey racetracks. These types of wagers proved to be very popular with New Jersey racing patrons. In response to this popularity, Assembly Bill 1940 was introduced in October of 1992, passed both houses of legislature and was signed into law on January 22, 1993 as P.L. 1993 c.24. Proposed new rule N.J.A.C. 13:71-27.56 will allow the implementation of these exotic wagers, with carry-over features, at New Jersey racetracks. These wagers, called Pick(N), require selection of the first place finishers in each of four or more consecutive races, with the letter (N) representing the number of such races.

**Social Impact**

The social impact of the proposed new rule is positive. These types of pools have proven to be popular when included in common pools from out-of-State tracks. The carry-over feature, in particular, will make these pools more interesting and will encourage a broader scope of participation by New Jersey racing patrons.

**Economic Impact**

The economic impact of the proposed new rule is positive. The carry-over provision of this rule is expected to generate increased handles at the New Jersey tracks which, in turn, will increase State revenue, provide additional pure monies to the horsemen, tracks and breeders programs without any increased cost.

**Regulatory Flexibility Statement**

The proposed new rule imposes no reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Assuming a racetrack association secures Commission approval for a Pick(N) format, it will assume compliance and recordkeeping responsibilities inherent in this or any wagering format. Those track associations which would assume such responsibilities are not small businesses, as each employ more than 100 people. Therefore, a regulatory flexibility analysis is not required.

**Full text** of the proposed new rule follows:

13:71-27.56 The Pick(N)

(a) The Pick(N) requires selection of the first place finishers in each of four or more consecutive races, with the letter (N) representing the number of such races. The association must obtain written approval from the Commission concerning the scheduling of Pick(N) events. Any changes to the approved Pick(N) format requires prior approval from the Commission.

(b) A carry-over, as is relevant to this section, is that percentage of the pool not paid out when no one successfully selects all winning horses in the Pick(N). The carry-over amount shall be added to the subsequent Pick(N) pool until distributed as a result of the successful selection of all winning horses.

(c) The Pick(N) pool shall be distributed under one of the following methods:

1. Method 1. Pick(N) with carry-over: The net Pick(N) pool and carry-over, if any, shall be distributed as a single price pool to those who selected the first place finisher in each of the Pick(N) contests, based on the official order of finish. If there are no such wagers, then 25 percent of the net pool shall be distributed as a single price pool to those who selected the first-place finisher in the greatest number of Pick(N) races; and the remaining 75 percent of the net pool shall be added to the carry-over.

2. Method 2. Pick(N) with minor pool and carry over: The major share of the net Pick(N) pool (75 percent) and the carry-over, if any, shall be distributed to those who selected the first-place finisher in each of the Pick(N) contests, based on the official order of finish. The minor share of the net Pick(N) pool (25 percent) shall be distributed to those who selected the first-place finisher in the second greatest number of Pick(N) contests based on the official order of finish. If there are no such wagers selecting the first-place finisher of all Pick(N) contests, the minor share of the net Pick(N) pool (25 percent) shall be distributed as a single price pool to those who selected the first-place finisher in the greatest number of Pick(N) contests based on the official order of finish and the major share (75 percent) shall be added to the carry-over.

(d) If there is a dead heat for first in any of the Pick(N) contests involving contestants representing the same betting interest, the Pick(N) pool shall be distributed as if no dead heat occurred. If there is a dead heat for first in any of the Pick(N) contests involving contestants representing two or more betting interests, the Pick(N) pool shall be distributed as a single price pool with each winning wager receiving an equal share of the net Pick(N) pool.

(e) The Pick(N) pool shall be held entirely separate from all other pools and is not a parlay and is not part of a daily double, exacta, trifecta or other wagering pool.

(f) Pick(N) tickets shall be sold in not less than $1.00 denominations and only from machines capable of issuing four or more numbers.

(g) Those horses constituting an entry or a field as defined within the rules of the Commission shall race in any Pick(N) race as a single wagering interest for the purpose of Pick(N) pari-mutuel pool calculations and payments to the public. A scratch after wagering has begun on any part of an entry or mutuel field in such a race shall be of no effect with respect to the status of such entry or field as a viable wagering interest.

(h) At any time after wagering begins on a Pick(N) pool should a horse, entire betting entry or mutuel field be scratched or declared a non-starter in any Pick(N) race, no further tickets selecting such horse betting entry or mutuel field shall be issued, and wagers upon such horse betting entry or mutuel field, for purposes of the Pick(N) pool, shall be deemed wagers upon the horse, betting entry or mutuel field upon which the most money has been wagered in the win pool at the close of win pool betting for such race. In the event of a money tie, the tied horse, betting entry or mutuel field with the most inside post position shall be designated.

(i) The Pick(N) pool shall not be cancelled based upon the number of race cancellations or races being declared no contest, unless the following is true, in which case all Pick(N) wagers for the individual performance shall be refunded:

1. Three or more races of a Pick 4 or Pick 5 are cancelled or declared no contest;

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2. Four or more races of a Pick 6 or Pick 7 are cancelled or declared no contest;

3. Five or more races of a Pick 8 or Pick 9 are cancelled or declared no contest;

4. Six or more races of a Pick 10 or Pick 11 or more races are cancelled or declared no contest.

(j) If, on the last day on which the system of wagering is conducted at a race meeting, no bettor selects the winning horse in those designated races, the total amount of the pool which exists on that day in connection with those races shall be paid to the bettor or bettors who selected the largest number of winning horses in those races.

(k) If, for any reason, the Pick(N) carry-over cannot be paid out on the last scheduled day of a race meeting, the carry-over shall be deposited in an interest bearing account approved by the Commission. The Pick(N) carry-over plus accrued interest shall then be added to the net Pick(N) pool on a race date determined by the Commission.

(l) An association, with the written approval of the Commission, may contribute funds to the net Pick(N) pool or the carry-over pool.

(m) Should circumstances occur which are not foreseen in this section, questions arising thereby shall be resolved with general pari-mutuel practice. Decisions regarding distribution of Pick(N) pools will be final.

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# TREASURY-GENERAL

# (a)

## STATE AFFIRMATIVE ACTION OFFICE (PUBLIC CONTRACTS)

## Affirmative Action Rules

## Proposed Readoption: N.J.A.C. 17:27

Authorized By: Samuel Crane, State Treasurer, Department of the Treasury.

Authority: N.J.S.A. 10:5-31 et seq., specifically N.J.S.A. 10:5-36K.

Proposal Number: PRN 1993-440.

Submit comments by September 15, 1993 to:

William Parrish, Chief
State Affirmative Action Office
(Public Contracts)
Department of the Treasury
CN 209
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

N.J.A.C. 17:27 governs the affirmative action employment standards and practices required of public agencies awarding contracts, public work contractors and subcontractors to comply with equal employment opportunity as mandated by N.J.S.A. 10:5-36 et seq., P.L. 1975, c.127. The rules define the public agency's responsibilities in awarding contracts, the contractor's responsibilities for compliance with these rules and the Affirmative Action Office's administrative procedures.

In accordance with the "sunset" provision of Executive Order No. 66(1978), N.J.A.C. 17:27 expires on October 7, 1993. The State Affirmative Action Office (Public Contracts) proposes to readopt the chapter. The Department of the Treasury has reviewed this chapter and has determined that N.J.A.C. 17:27 continues to be reasonable, necessary and proper for the reasons it was originally adopted.

Subchapter 1 delineates the policy of the Department regarding affirmative action in the awarding of contracts funded by the State of New Jersey.

Subchapter 2 contains definitions used in this chapter.

Subchapter 3 contains general requirements for public agencies which award contracts.

Subchapter 4 outlines affirmative action plan requirements for procurement and service contractors and subcontractors.

Subchapter 5 delineates minority and female employment goal obligations for procurement and service contractors and subcontractors.

Subchapter 6 outlines the affirmative action plan for construction contractors and subcontractors.

Subchapter 7 delineates minority and female employment goal obligations for construction contractors and subcontractors.

Subchapter 8 contains provisions regarding local advisory board recommendations.

Subchapter 9 contains provisions regarding the monitoring of public works contracts.

Subchapter 10 delineates the compliance requirements and sanctions which apply to public works contracts.

Subchapter 11 contains provisions regarding the furnishing of reports to the Department by public works contractors, subcontractors and public agencies.

Subchapter 12 outlines requirements for training and outreach to minorities and women.

Originally adopted in 1977 (see 9 N.J.R. 191(a) and 543(c)), these rules were last readopted, with amendments, in 1988 (see 20 N.J.R. 1780(a), 2795(b) and 2934(a)). Amendments were adopted in 1978 and 1979 (see 10 N.J.R. 209(a) and 305(a), and 11 N.J.R. 208(c) and 305(c), respectively).

**Social Impact**

The State Affirmative Action Office anticipates that a positive social impact will result from the readoption of this chapter. The readoption will assure continued progress in the employment and upgrading of minorities and females within the workforce. No negative impact is anticipated.

**Economic Impact**

No change in economic impact on public works contractors is anticipated, because there is no increase in requirements.

The current economic impact of the rules cannot be determined exactly, due to the number and variety of businesses involved. The impact of the required reporting and recordkeeping on larger businesses can be substantial, although it is derived from the personnel records customarily maintained by each company. In addition, the documentation maintained as required by this chapter is consistent with that required by the federal government. The impact on small businesses (those employing 50 or fewer people) is negligible, and consists primarily of the costs involved in securing a notarized document each year for each governmental agency with which the small business has a contract.

**Regulatory Flexibility Analysis**

The rules proposed for readoption will have an impact on those small businesses, as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., which contract with public agencies. The number and kind of small businesses fluctuate, depending upon the work required. Notarized affirmative action affidavits need not be used by contractors who employ 50 or less people, with the effect of streamlining the bid process for these small businesses. The form used is given to the business by the agency, at no cost to the business. The form to be used in lieu of the affidavit can be executed on the spot and does not require notarizing, thus the award process will be made less time-consuming. The use of the Employee Information Report also means that small businesses will have a certificate to use in the bidding process, with each agency thereby eliminating the need to have an affidavit on file with each public agency with which they have contracts. This provision has the effect of easing requirements for those small businesses employing 50 or fewer people. Those small businesses employing more than 50 people are required to comply with the provisions of this chapter, due to overriding public policy concerns regarding the implementation of the affirmative action in the State of New Jersey.

**Full text** of the proposed readoption can be found in the New Jersey Administrative Code at N.J.A.C. 17:27.

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# HEALTH

## (a)

## HOSPITAL REIMBURSEMENT

### Charity Care Audit Functions

### Proposed Repeal: N.J.A.C. 8:31B-4.41

### Proposed New Rules: N.J.A.C. 8:31B-4.41 through 4.41N

Authorized By: Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Authority: P.L. 1992, c.160 and N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5b and 25:2H-18(d).

Proposal Number: PRN 1993-449.

Submit comments by September 15, 1993 to:
Health Care for the Uninsured Program
New Jersey Department of Health, Room 403
CN 360
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

The Health Care Reform Act of 1992, P.L. 1992, c.160, eliminated the State's system of setting reimbursement rates for acute care hospitals, which guaranteed that hospitals would be fully reimbursed for uncompensated care, defined as the provision for bad debt and charity care. Under the new legislation, hospitals may qualify for charity care subsidies based on a statutory formula, and the Department is required to conduct an audit of hospitals' charity care.

These proposed new rules set forth the guidelines under which the Department will conduct its audit of 1993 charity care. The major components are as follows:

- The charity care accounting methodology; this is to ensure accurate monitoring of charity care costs as well as to establish a uniform basis for analyzing charity care costs;
- The sampling methodology, which describes the manner in which the Department of Health shall select charity care accounts to be audited;
- The financial screening requirements which hospitals must complete on each patient to verify his or her insurance status and/or eligibility for any third party assistance program;
- The compliance testing component of the audit; this portion includes the charity care eligibility criteria, and the documentation requirements; and
- The adjustment methodology, which describes the methods the Department will use to adjust its estimates of charity care when hospitals do not comply with these rules.

These rules build upon the basic approach that was taken to auditing the charity care component of uncompensated care under the State's ratesetting system. Those audits required hospitals to take certain steps to verify that individual patients met eligibility criteria for charity care set out in law or regulation. If hospitals failed to take these required steps, they were not guaranteed reimbursement for the patient's care. In these rules, the Department continues to specify eligibility criteria that will be used to establish a patient's eligibility for charity care, including income, assets, availability of third party coverage and New Jersey residency. The requirement that hospitals document a patient's eligibility is maintained; however, hospitals are afforded more flexibility in demonstrating that they have verified the patient's eligibility for charity care. This is consistent with the recommendations of the Health Care Cost Reduction Advisory Committee (HCCRAC), a committee established by P.L. 1991, c.187. HCCRAC deliberated a variety of approaches to auditing charity care, and concluded that hospitals should be given more flexibility in documenting charity care eligibility. HCCRAC believed that a realistic assessment of the circumstances under which patients receive hospital services and arrange for payment required a more flexible approach to auditing hospital's provision of charity care.

**Social Impact**

Conducting an audit pursuant to these rules will provide information on the current delivery of charity care by New Jersey acute care hospitals. This information will influence future subsidy distributions, and may influence the other health care reform initiatives under the Health Care Reform Act, such as the design of subsidized insurance programs.

The proposed new rules will ensure that patients that qualify for partial charity care assistance are billed for the appropriate balance.

**Economic Impact**

Hospitals' 1993 subsidy amounts will not be adjusted as a result of the audit. The audit results, however, may also affect 1994 charity care subsidy amounts, since the results will be used to develop policy in the future.

The rules provide for the auditing of provisions of the Health Care Reform Act which expand the income and assets eligibility criteria. The rules require no new action on the part of the hospitals, regarding screening and verification. The compliance testing portion of the rules is not expected to create a significant expense, since records have been already established and maintained. These rules simply describe the sampling procedures and the timeframes required.

**Regulatory Flexibility Statement**

The proposed new rules, in the hospital licensing standards would not affect small businesses, as the term is defined in the Regulatory Flexibility Act, 52:14B-16 et seq. The hospitals in New Jersey all employ more than 100 people. Businesses other than hospitals would not be affected. Therefore, a regulatory flexibility analysis is not required.

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

[8:31B-4.41 Uncompensated care audit functions

(a) Hospitals shall maintain their annual bad debt and charity care lists in a way that will allow the Department of Health to select accounts for dollar sampling. Hospitals will be required to rank order all bad debt and charity care accounts from the smallest to the largest and run a cumulative balance on the list. These lists must be available to the Department of Health by May 1 following the rate year.

(b) Hospitals shall submit, on a yearly basis, verifiable data in the following format:

1. The ratio of the provision for bad debt to patient services revenue;

2. The ratio of the reserve for bad debt to accounts receivable; and

3. The ratio of actual write-offs (net of recoveries) to patient services revenue.

(c) This procedure entails a comparative analysis of pertinent current year's ratios and the multiyear trend. These ratios shall include a three year trend for 1987, a four year trend for 1988, and a five year trend for 1989 and all subsequent years.]

**8:31B-4.41 Charity care audit functions**

**The Department of Health will conduct an audit of acute care hospitals' charity care in calendar year 1993 in accordance with N.J.A.C. 8:31B-4.41A through 4.41N.**

**8:31B-4.41A Sampling methodology**

**(a) The Department of Health will audit charity care claims based on a sample which will be developed in the following way:**

**1. Hospitals shall maintain their charity care list in a way that will allow the Department of Health to select accounts for unit dollar sampling. Hospitals shall rank order all charity care accounts from the smallest to the largest, based on the rate that Medicaid would have paid for each account, and run a cumulative dollar balance on the list. Once the selection of sample dollars has been completed and the associated patient accounts have been identified, hospitals will be required to retrieve the patient account files according to the following schedule:**

| Number of files to be retrieved | Time to retrieve |
|---|---|
| 300-500 files | One week |
| 501-1100 files | Two weeks |
| 1101-1800 files | Three weeks |
| 1801 files and above | Four weeks |

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(b) The Department of Health will require hospitals to make a small number of additional charity care accounts available upon audit.

8:31B-4.41B Charity care write off amount

(a) Hospitals shall record inpatient and outpatient charity care write-off amounts at the rate paid by the Medicaid program on the date that the service was provided as described in (a)1 below. Inpatient Medicaid rates are determined by grouper assignment applied to the rate per case amounts established by the Medicaid Program. Outpatient Medicaid rates are determined using Medicaid principles for a given outpatient service. In the event that a hospital did not record all charity care write-offs at the Medicaid rate, the hospital must convert such accounts to the Medicaid rate in preparing the charity care list for audit.

1. Charity Care Write Off Amount = (Charity Care Eligibility Percentage, as determined by N.J.A.C. 8:31B-4.41H) × (Medicaid Payment Rate)

2. In the event that there is a partial payment from a third party, the charity care write-off amount is determined as follows:

Charity Care Write Off Amount = (Medicaid Payment Rate – Third Party Payment) × (Charity Care Eligibility Percentage)

3. If the third party payment is greater than the Medicaid payment rate, then the charity care write-off amount shall be listed as 0.

(b) Patients eligible for charity care at 100 percent shall not be billed. Any difference between hospital charges and the Medicaid rate shall be recorded as a contractual allowance.

(c) Patients eligible for charity care at less than 100 percent shall be billed as follows:

Patient Responsibility = (100% – Charity Care Eligibility Percentage) × (Hospital Charges – any third party payment)

Contractual allowance = (Hospital Charges) – (Charity Care Write Off + Patient Responsibility)

8:31B-4.41C Posting of notice of availability of charity care

(a) Hospitals shall post notification of the availability of charity care as follows:

1. The Department shall provide to acute-care hospitals notices in English and Spanish about the availability of charity care and reduced charge charity care. Hospitals shall post such notices, provided by the Department, of the availability of charity care in areas of the facility readily accessible and visible to incoming patients, including but not limited to, the admissions area, the business office, outpatient clinic areas, and the emergency room.

2. If the usual language of the households of 10 percent or more of the population in the service area of the facility, according to the most recent figures published by the Bureau of Census, is other than English or Spanish, the facility shall notify the Department, who shall translate the notice into that language and supply the posted notice to the facility. The facility shall then also post the translated notice.

3. The Department shall request the auditors to complete a list of all hospitals which failed to post the charity care notification signs described in (a)1 and 2 above.

(b) Hospitals which failed to post the notification signs will be required to place an advertisement in their local newspaper notifying the public that the hospital will accept applications for patients who received services prior to the date when the signs were placed.

8:31B-4.41D Charity care screening and documentation requirements

(a) The hospital shall correctly assess and document the patient's eligibility for charity care, based upon the criteria set forth in N.J.A.C. 8:31B-4.41A through N. The patient's financial file for audit shall contain the completed charity care application, as well as the supporting documentation which led to the determination of eligibility.

(b) The hospital shall ask the patient if he or she has any third party health insurance. If the patient claims to have insurance, the hospital shall document the name of the insuror and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified; or the reason why the coverage could not be verified.

(c) If the patient is uninsured, or the patient's health insurance is unlikely to pay the bill in full (based on hospital staff's previous experience with the insurer), and the patient has not paid, at the time of service, any amounts likely to be remaining, the hospital shall make an initial determination for eligibility for any medical assistance programs available. The hospital shall refer the patient to the appropriate medical assistance program and shall advise the medical assistance office of the patient's possible eligibility. The patient's financial file for audit shall indicate either that the patient declined to be screened for medical assistance; that the patient was screened but was determined ineligible; or that the patient was screened and referred to the New Jersey Medicaid medical assistance program for possible eligibility. If the hospital does not screen the patient for medical assistance, the record shall indicate the reason(s) why the patient was not screened and the efforts the hospital made to obtain the screening. A patient shall not be screened for charity care if the patient declines to be screened for medical assistance or if the patient does not receive a denial from the medical assistance agency.

(d) Hospitals shall make arrangements for reimbursement for services from private, and Federal, state and local government third party payers when a person is found to be eligible for such payment. Hospitals shall collect from any party liable to pay all or part of a person's bill, prior to attributing the services to charity care except in the situation described in (h) and (i) below. The hospital shall, as part of this obligation, pursue reimbursement for the uncollected copayments and deductibles of indigent participants in Title XVIII of the Social Security Act (Medicare).

(e) A patient who is categorically and income-eligible for Medicaid but who is determined to be ineligible for failure to provide information or documentation or for other administrative reasons shall not be determined to be eligible for charity care.

(f) A patient who is responsible for complying with his or her insuror's pre-certification requirements (the specific steps with which the insured must comply in order to have the services reimbursed) shall not be determined to be eligible for charity care, if the bill was unpaid because he or she failed to comply with these requirements.

(g) A patient who is determined to be eligible for and accepted into the HealthStart or HealthStart Plus Programs shall not be deemed eligible for charity care for services which are covered under those programs.

(h) Applicants who are eligible for reimbursement under the Violent Crimes Compensation Program shall be screened for eligibility for the charity care program before referral to the Violent Crimes Compensation Program. If the applicant is not eligible for 100 percent coverage under the charity care program, then the patient shall be referred to the Violent Crime Compensation Program.

(i) Applicants who are eligible for reimbursement under the Catastrophic Illness in Children Relief Fund shall be screened for eligibility for the charity care program in accordance with N.J.A.C. 8:18 before referral to this Program. If the applicant is not eligible for 100 percent coverage under the charity care program, then the patient shall be referred to the Catastrophic Illness in Children Relief Fund.

8:31B-4.41E Identification

(a) Applicants for charity care shall provide the hospital with proper identification:

1. Documentation of identification may include, but is not limited to, a driver's license, a voter registration card, an alien registry card, a birth certificate, an employee identification card, a union membership card, an insurance or welfare plan identification card or a Social Security Card. Identification may also be documented by personal recognition by a person not related to the patient.

(b) Hospitals shall obtain a copy of the applicant's identification and produce the copy on audit. The copy of identification may be made in one of two ways: a photocopy of the identification may be

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made; or hospital staff may copy all pertinent information from the identification source, such as, driver's license number, passport/visa number, and put this information in the patient file for audit. If documentation of identification is provided by personal recognition by a person not related to the patient, the record must include the name, address and phone number of the person who provided the recognition.

(c) Hospitals shall attempt to collect the following information regarding the patient and responsible party (if applicable): name, mailing address, residence telephone number, date of birth, Social Security number, place and type of employment, employment address and telephone number, as applicable.

8:31B-4.41F New Jersey residency

(a) Applicants shall provide the facility with proof of New Jersey residency. Proper proof of New Jersey residency includes the following items: any of the identification listed in N.J.A.C. 8:31B-4.41E which contains the applicant's mailing address, a copy of a deed or lease to a property in New Jersey, an article of mail sent to the patient at a New Jersey address, or a letter from a New Jersey resident with whom the applicant is living stating that the applicant resides with him or her.

(b) An applicant shall provide proof that he or she has been residing in New Jersey for at least three months prior to the date of service, and that he or she has the intent to remain in the State.

(c) Persons who are not New Jersey residents shall not be screened for charity care, unless the care results from an emergency situation requiring immediate medical care. Hospitals shall not report care delivered to non-New Jersey residents as charity care, unless the care is related to an emergency situation requiring immediate medical care. Hospitals shall not report the costs of services delivered to persons who come to New Jersey for the purpose of receiving medical care as charity care.

8:31B-4.41G Documentation of family size

The hospital shall properly determine the applicant's family size in accordance with this section. Family size for an adult applicant includes the applicant, spouse, any minor children whom he or she supports, and adults for whom the applicant is legally responsible. The family size for a minor applicant includes both parents, or a spouse of a parent, minor siblings and any adults in the family for whom the applicant's parent(s) are legally responsible. If an applicant documents that he or she has been abandoned by a spouse or parent, then that spouse or parent is not included as a family member. A pregnant female counts as two family members.

8:31B-4.41H Income eligibility criteria and documentation

(a) The provisions of 42 U.S.C. 990c(2), the poverty income guidelines revised annually by the United States Department of Health and Human Services, are hereby incorporated by reference. (For further information on the poverty income guidelines, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C. 20201, telephone 202-245-6141). A person is eligible for charity care or reduced charge charity care if he or she falls into one of the following categories:

1. A person whose individual or, if applicable, family income, as determined by reference to (b) below, is less than or equal to 200 percent of the HHS Income Poverty Guidelines shall be eligible for charity care for necessary health services without cost.

2. A person whose individual or, if applicable, family income as determined by reference to (b) below, is greater than 200 percent of the HHS Income Poverty Guidelines but not more than 300 percent of these guidelines is eligible at a reduced rate as described in subsection (b) below.

(b) A person who is eligible for reduced charge health services shall be charged a percentage of the normal charge for health services as follows: the reduced percentage can be applied to the total bill or to any remainder after third party payment.

| Income as a Percentage of HHS Income Poverty Guideline | Percentage of Charges Paid by Patient |
|---|---|
| >200 to 225 | 20 |
| >225 to 250 | 40 |
| >250 to 275 | 60 |
| >275 to 300 | 80 |

(c) If the liability (which is unpaid by other parties and billed to the patient) for individuals with incomes between 200 and 300 percent of the Federal poverty guidelines to the patient exceeds 30 percent of the person's, or family's if applicable, annual gross income as calculated by reference to (b) above, this excess will be eligible for 100 percent coverage under the charity care. This 30 percent threshold must be met once per family in a 12 month period.

(d) A person's income, for purposes of determining eligibility for charity care or reduced charge charity care, shall be determined as follows:

1. The applicant may provide proof of the actual gross income for the 12 months immediately preceding the services;

2. The applicant may provide proof of actual gross income for the three months immediately preceding services. The facility will multiply this amount by four to determine the gross annual income; or

3. The applicant may provide proof of actual gross income for the prior month immediately preceding service. The facility will multiply this amount by 12 to determine the gross annual income.

4. If the applicant provides documentation for more than one salary period, the facility shall use the period of time during which the salary was the lowest.

5. If the applicant is a welfare recipient, the facility may document income status by obtaining a photocopy of the applicant's welfare identification, and documenting that the staff of the facility communicated with the local welfare office to verify the applicant's current benefit amount.

6. An applicant may request that unreported income be considered in the eligibility determination, as described in N.J.A.C. 8:31B-4.41I(b).

8:31B-4.41I Proof of income

(a) Proof of income shall include Federal or state income tax return, pay check stubs, W-2 forms, a letter from an employer on company letterhead stating the applicant's income, or a statement of the gross benefit amount from any governmental agency providing benefit to the applicant. An applicant may document his or her income by providing one paycheck stub immediately prior to the date of service if the paycheck stub indicates a year to date income, and if the applicant documents the length of time he or she has been employed by the employer.

1. An applicant may document unreported income, by signing an attestation which states the income obtained in one of the time periods described in N.J.A.C. 8:31B-4.41H(d)1, 2 or 3. The facility may request that the applicant document his or her living expenses for the same time period.

2. An applicant who receives no income or benefits may provide the hospital with an attestation(s) from organizations, or people providing the applicant with support. If the applicant has not received cash assistance, the applicant will be evaluated at $0 gross income.

3. If the applicant is homeless, the facility may accept a signed attestation from the applicant which states that he or she is homeless and receives no support, income or benefits.

(b) Family income that must be considered for the eligibility determination includes the income of all members for whom the applicant is legally responsible including, but not limited to, a spouse and any minor children for an adult. For a minor applicant, the income of the family, as determined by N.J.A.C. 8:31B-4.41H, will be considered. In situations where a minor applicant's parents are divorced, and the custodial parent(s) are remarried, the non-parental spouse's income shall be considered. In situations where both divorced parents have responsibility for the minor applicant's medical care each parent shall complete a charity care application.

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For a minor applicant the income of the family shall be considered. Only unearned income shall be considered for minor children and siblings. In cases where an adult applicant has been abandoned by a spouse, or a minor applicant has been abandoned by a parent, the applicant may document that a spouse's or parent's income is not available.

(c) If a minor applicant's parents are divorced, and one of the parents is uncooperative, as explained in (c)1 through 3 below, with the application process, then the requirement for that parent's income may be waived after the case is reviewed by the Department of Health.

1. A parent or spouse may be deemed uncooperative if the applicant documents the unsuccesful attempts to obtain the necessary information from the parent or spouse; and

2. The parent or spouse does not respond to a letter from the hospital threatening collection or legal action if he or she does not provide the necessary information for the application; and

3. The parent or spouse does not respond to the hospital's in-house collection process.

(d) The hospital may request that the applicant document his or her living expenses.

8:31B-4.41J Assets eligibility criteria

(a) An individual is eligible for charity care or reduced charge charity care if:

1. His or her individual liquid assets as of the date of service do not exceed $3,000; and

2. His or her family's liquid assets, if applicable, do not exceed $6,000 as of the date of service.

(b) Family members whose assets must be considered are all legally responsible individuals as defined in N.J.A.C. 8:31B-4.41I(b).

(c) Liquid assets are assets which consist of, or which can be readily converted into, cash. This includes, but is not limited to, cash, savings and checking accounts, certificates of deposit, treasury bills, negotiable paper, corporate stocks and bonds, IRAs (Individual Retirement Accounts), trust funds, and equity in real estate other than the patient's or family's, if applicable, primary residence. A primary residence, for purposes of charity care, is defined as a residence zoned for a single family in which the applicant currently lives.

(d) Where applicable, the applicant may document his or her or family liquid assets by presenting the hospital with documentation of the value of any of the assets as of the date of service, or, in the case of a checking or savings account, provide a statement of the average daily balance of the accounts for the month in which he or she received services.

(e) The assets of an applicant for charity care shall be counted only after the applicant has had an opportunity to apply any amount of assets in excess of the limits in (a) above to the hospital charges for which the applicant seeks charity care.

8:31B-4.41K Additional information to be supplied to facility by applicant

A facility shall, as a condition of finding any applicant eligible for charity care or reduced charge charity care, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income and assets and that is within the applicant's ability to supply.

8:31B-4.41L Application and determination

(a) The Department of Health shall provide acute care hospitals with a standardized application and determination form. This application and determination form shall be used by all acute care hospitals for the charity care program.

(b) A patient or responsible party may request a facility to make a determination for charity care or reduced charge charity care at any time up to one year from the date of service. A hospital may, at its discretion, accept applications after one year from the date of service. Such a determination shall be made as soon as possible, but no later than 10 working days from the day of the request. If the request does not include sufficient documentation to make such a determination, then the applicant shall be permitted to supply additional documentation. The hospital shall promptly provide the applicant with a written copy of its final determination.

(c) A determination that an applicant is eligible shall indicate:

1. The date on which the eligibility determination was made;

2. The date on which hospital services were requested;

3. The date on which the services were or will be provided to the applicant;

4. That the facility will provide charity care services at no charge or at a specified charge which is less than the allowable charge for the services;

5. The applicant's family size, income and eligibility computation; and

6. The length of time that the hospital will provide charity care based on this determination. A hospital shall not provide charity care on the basis of a determination of eligibility that is more than one year old.

(d) The facility shall provide each applicant who requests charity care and is denied it, in whole or part, with a written and dated statement of the reasons for the denial, including information required in (c) above. In addition, this notice shall state that the applicant may reapply if the applicant believes his or her financial circumstances have changed so as to make him or her eligible for charity care for future services. Where a denial is based on a presumption that the patient is eligible for, but not enrolled in, Medicaid, the information upon which the denial is based must be documented.

8:31B-4.41M Collection procedures and prohibited action

Persons determined to be eligible for charity care shall not receive a bill for services or be subject to collection procedures. Persons determined to be eligible for reduced charge charity care shall not be billed or subject to collection procedures for the portion of the bill that is reduced charge charity care. If the portion of the bill that will be charity care cannot be determined prior to billing because third party payments have not been made, any statements shall indicate that the portion of the bill eligible for reduced charge charity care will be identified at a future date.

8:31B-4.41N Adjustment methodology

(a) For listing adjustment, the charity care write off amount for each account should agree with the reimbursement rate that would have been paid to the hospital by the Medicaid program. To the extent that charity care write off amounts are overstated, the hospital's listing total will be reduced by the percentage of overstatement found in the sample accounts.

(b) For compliance adjustment, each file reviewed must pass the eight compliance steps in N.J.A.C. 8:31B-4.41D through 4.41M. Failure in any one step would fail the file and associated sample dollars. A failure rate (failed dollars/total dollars sampled) that meets or exceeds 10 percent would require an adjustment to the hospital's charity care listing total based on unit dollar sampling.

(c) The hospital's adjusted charity care listing total will constitute the hospital's audited 1993 charity care amount.

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## (a)

## DIVISION OF HEALTH CARE PLANNING, FINANCING AND INFORMATION SERVICES

### Certificate of Need: Hospital Policy Manual Hospital Capital Cap and Review Process

### Proposed Amendments: N.J.A.C. 8:33A-1.10, 1.16 and 1.29

Authorized By: Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with the approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Proposal Number: PRN 1993-448.

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Submit comments by September 15, 1993 to:
John J. Gontarski, Acting Director
Health Planning and Community Initiatives, Room 401
New Jersey Department of Health
CN 360
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

The proposed amendments are being introduced by the Department of Health in order to establish an orderly process of certificate of need review for the 1993 call for hospital acute care projects that are expected to be submitted later in the year. Amendments are also being proposed in response to recommendations and concerns expressed by the Hospital Inpatient Services Technical Advisory Group (HISTAG), which is a task force convened by the Department of Health in conjunction with the State's six Local Advisory Boards. The HISTAG was charged with the task of developing a bed need methodology for acute care services in the State. As an outgrowth of this mission, the advisory group recommended clarification and inclusion of objective standards in the process for selecting suitable projects under the current $225 million annual capital cap. Therefore, a major amendment being proposed herein seeks to establish more objective criteria for prioritizing projects in the hospital capital batch at N.J.A.C. 8:33A-1.29.

Existing criteria have been expanded to include the use of adjusted occupancy in determining a hospital's community need, more specific definition of project goals and changes in the use of financial criteria.

Also amended is N.J.A.C. 8:33A-1.10, where applicants are directed to negotiate their projects, while still in the planning stages, with their respective LABs in order to assure that the goals of the prioritization criteria are met beforehand.

At N.J.A.C. 8:33A-1.10(a), an applicant for the addition or expansion of licensed beds must demonstrate the need for those beds in accordance with the most recent bed need estimates developed by the Department. Also, all applicants, prior to submission, should negotiate their plans with their respective LABs to assure that the proposed project addresses the hospital capital cap prioritization criteria.

At N.J.A.C. 8:33A-1.10(c), the one-time exception (for the December 1992 call) to the LAB bed need study requirement is eliminated.

At N.J.A.C. 8:33A-1.16, amendments are proposed to assure that the financial feasibility section of the certificate of need application will be filed consistent with Department of Health requirements contained in the rules, as revised by this proposal.

At N.J.A.C. 8:33A-1.29(b)1i, the prioritization criteria have been amended to establish a more realistic occupancy threshold and to permit applicants to improve their ranking by adjusting their licensed bed complement for those beds not targeted for expansion.

At N.J.A.C. 8:33A-1.29(b)1ii, language is being added to specify the manner in which average length of stay will be assessed for appropriateness.

At N.J.A.C. 8:33A-1.29(b)2i, clarifying language is provided regarding the type of licensing deficiency which would warrant priority consideration.

At N.J.A.C. 8:33A-1.29(b)3i and ii, language is added to specify the types of public health priorities that would be considered for priority consideration under the project goal category.

At N.J.A.C. 8:33A-1.29(c), the amendment clarifies the extent that financial criteria will be used in the prioritization process.

**Social Impact**

The Department of Health, through the Hospital Policy Manual, seeks to implement public policy which is directed towards improving the health of residents and towards increasing the accessibility, acceptability, continuity, and quality of services provided to them. Through these amendments, the Department will improve the decision-making process on competitive hospital modernization/renovation projects whereby those projects which best address the aforementioned goals are approved.

**Economic Impact**

The proposed amendments are, in general, expected to have a minimal economic effect on the healthcare system of New Jersey through encouragement of the efficient utilization of inpatient beds and the associated reduction in unnecessary capital and operational expenditures. The intent of the amendments to the rules is to improve the decision-making process used for the granting of CNs for capital projects, in order to distribute the available funds more effectively. The rules are expected, with the applicable statutes, to improve allocation of the available funds established by P.L. 1991, c.183.

**Regulatory Flexibility Statement**

The proposed amendments, as part of the Hospital Policy Manual, affect only acute care general hospitals, which typically employ well over 100 full-time employees. Therefore, these rules impose no requirements on small businesses, as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and no regulatory flexibility analysis is required.

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

8:33A-1.10 Bed need

(a) Any application for establishment of or expansion of licensed beds must demonstrate need for these beds in the proposed service area based upon needs assessment methodologies represented [in adopted health planning rules governing regionalization of the service(s)] **in the most recent acute care bed need estimates developed and promulgated by the Department. All applicants, prior to submission, should consult with their respective LABs regarding their plans to assure that the projects address community needs, project needs, project goals, cost issues and revenue stability criteria (to the extent that this information is available) and will be competitive in accordance with the review process for the hospital capital cap at N.J.A.C. 8:33A-1.29.**

(b) (No change.)

[(c) Notwithstanding N.J.A.C. 8:100-14.8(b) and 14.13, which require that a LAB bed need study be approved by the State Health Planning Board before any hospital within the counties identified in the subchapter above is permitted to submit a certificate of need application related to inpatient acute care services, and N.J.A.C. 8:33A-1.29(b)1ii, which includes county bed need as one of the community prioritization criteria, for the December 1992 call only, hospitals may submit certificate of need applications regardless of the existence of an approved LAB bed need study for acute care hospital capital expenditures.]

8:33A-1.16 Standards regarding equity contributions and financing

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

(d) All applicants shall demonstrate the financial feasibility of their projects. An appropriate financial feasibility study shall be submitted for projects in excess of $15 million at the time of application. **The financial feasibility study shall be prepared by an accounting firm approved by the New Jersey Health Care Facility Financing Authority for such studies, and shall express an opinion based on an examination of projections in the American Institute of Certified Public Accountants' Guide to Prospective Financial Information.** [The study must test the feasibility of the project under reimbursement rules in effect at the time of the application.] A project will be determined financially feasible where the applicant can demonstrate a net positive income [for] **beginning in** the calendar or fiscal year[s] which [are] **is** two [and five] years beyond project completion. Financial projections shall be provided for the first five full years after project completion. **These projections shall indicate the method of funding any losses incurred during this time period.**

(e) [Capital costs associated with approved Certificate of Need applications will not be guaranteed future reimbursement.] **All projects will be evaluated based on relative cost considerations in comparison to Statewide norms including capital expense per adjusted admission, and total operating expense per adjusted admission.**

8:33A-1.29 Hospital capital cap and review process

(a) (No change.)

(b) [The following criteria shall be used in identifying priority projects in the review of certificates of need subject to the Statewide cap. Those certificate of need projects proposing a capital expenditure where the following factors are demonstrated within the application shall be identified as having priority for approval:] **Hav-**

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**ing met all other applicable criteria in this chapter and N.J.A.C. 8:33, for the 1993 and 1994 hospital acute care calls only, projects shall be prioritized according to the criteria below. Those projects meeting the greater number of criteria shall receive priority consideration for approval. Approval of certificates of need as limited by the Statewide cap of $225,000,000 will be determined based on the prioritization criteria.**

1. Community need: A hospital will be deemed to have exhibited priority community need when it has the following characteristics:

i. Occupancy in excess of optimal occupancy rates (as specified in N.J.A.C. 8:33A-1.11(a)) in all services **proposed for expansion, and adjusted occupancy rates in excess of minimum rates by at least 10 percent in all other bed categories** during the last [calendar year] **18 months** preceding the application. [Services proposed for closure in the application may be excepted; and] **Adjusted occupancy, for each bed category not being expanded, shall be calculated as follows:**

**(1) Adjusted bed-day capacity = Licensed beds in a category minus changes in beds in the category multiplied by the total days in the 18 month period (547 days);**

**(2) Adjusted occupancy = Actual patient days in the categories in the prior 18 month period (547 days) divided by the adjusted bed-day capacity for that category; and**

[ii. The county in which the hospital is located has been determined to have a bed need; and]

[iii.]**ii.** The county's and hospital's rates of inpatient admission and length of stay have been demonstrated to be appropriate and not likely to decline as a result of changing medical practice or reimbursement policy[;]. **Appropriateness of a hospital's average length of stay (ALOS) shall be determined by comparison, in each licensed bed category, to the Statewide average ALOS for that category. A hospital ALOS, in any bed category, in excess of the Statewide ALOS for that category by more than 20 percent shall be considered inappropriate. A hospital whose ALOS, in any bed category, has been deemed inappropriate in the above manner shall provide justification to the Department. The Department will evaluate such justifications and make a determination of appropriateness of the ALOS, based upon the data provided by the hospital, as well as data maintained by the Department. If the Department determines that a hospital's ALOS is appropriate, even though it exceeds the Statewide ALOS plus 20 percent, an exception to this criterion may be made.**

2. Project need:

i. The project is substantially directed to correcting Life Safety Code [A or B level] deficiencies, or other conditions [posing] **that pose** imminent peril to **the** health and safety of patients and staff; **or** [and

ii. The hospital has not implemented a major modernization or construction program in the affected areas of the project for a period in excess of 10 years; or

iii.]**ii.** The overall average age of the physical plant exceeds 10 years based on the Department's calculations using generally accepted accounting principles; and

3. Project goals:

**i.** The certificate of need application has been submitted in order to address a **public health** priority or a specific recommendation [that is identified in the State Health Plan] **set forth in Department health planning guidelines**, and is determined by the Department to be essential to achieving that goal. [These in specific] **Specifically, these may** include hospital closure or merger applications that demonstrate significant cost savings to the health care system, **projects which significantly and demonstrably improve access for populations which have been shown historically to lack access to hospital services,** or projects implementing ambulatory care initiatives that improve health care delivery patterns and reduce system expenditures[.]; **and**

**ii. The facility historically has served a greater than average proportion of medically underserved populations in comparison to the percent of the population in its community; meets Federal and State obligations for providing uncompensated care, community services, access by minorities (race, ethnic, others) and special needs populations (for example, AIDS); offers a range of means by which persons will have access and availability to its services (for example, outpatient services, admission by house staff, admission by personal physician); is accessible by public or private transportation; as applicable, assures effective communication between the staff of the proposed project and non-English speaking people and those with speech, hearing, or visual handicaps; and to the extent possible, eliminates architectural barriers to care for handicapped individuals and/or describes other unique circumstances.**

(c) [Projects shall demonstrate at least one of the prioritization criteria in (b) above.] The strength of the demonstration and the number of prioritization factors demonstrated will be considered in the ranking of projects. The projects will also be [prioritized for affordability. Indicators of affordability are the total project cost, cost per adjusted admission, and the institution's ability to obtain low cost financing.] **evaluated based on relative cost considerations including total operating expense per adjusted admission and capital expense per adjusted admission in comparison to Statewide medians.**

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# (a)

## DIVISION OF HEALTH PLANNING, FINANCING AND INFORMATION SERVICES

## Certificate of Need: Cardiac Diagnostic Facilities and Cardiac Surgery Centers

## Proposed New Rules: N.J.A.C. 8:33E

Authority: N.J.S.A. 26:2H-5 and 26:2H-8.

Proposal Number: PRN 1993-447.

Submit comments by September 15, 1993 to:
John J. Gontarski, Acting Director
Health Planning and Community Initiatives
New Jersey Department of Health
Health System Review, Room 401
CN 360
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

The Department of Health is proposing a new chapter that establishes minimum standards and criteria for the provision of invasive cardiac diagnostic services and cardiac surgery services. The initial subchapter (N.J.A.C. 8:33E-1) applies to the provision of invasive cardiac diagnostic services in settings where cardiac surgery is not also offered. The companion subchapter (N.J.A.C. 8:33E-2) establishes standards and criteria for the provision of cardiac services in cardiac surgery centers, which by definition offer both cardiac diagnostic and therapeutic interventions (for example, cardiac surgery, coronary or balloon angioplasty, complex electrophysiology) on site. This new chapter is intended to replace a previous chapter (formerly at N.J.A.C. 8:33E) which expired on June 23, 1992 pursuant to the sunset provisions of Executive Order No. 66 (1978).

The Department of Health is in the process of reviewing the entire spectrum of public policy regarding cardiovascular disease, with the assistance of the newly formed cardiovascular health advisory panel (CHAP). Included in this review process, will be a comprehensive examination of Statewide cardiovascular health promotion, disease prevention, and treatment strategies that may greatly influence future resource allocation policy contained in this chapter. The Department is therefore proposing the establishment of interim policies that permit limited expansion of existing invasive cardiac laboratory resources, under carefully structured conditions, which document serious problems regarding access to timely services. The proposed chapter contains sections regarding new cardiac services that will be reserved pending the completion of the Department's policy review. A two year limitation on this chapter is being proposed as assurance that the review will be completed in a timely fashion. The Department's review will include an examination of both the utilization and performance of the State's existing invasive cardiac diagnostic and cardiac surgery resources.

This proposed chapter includes the restatement of Department of Health acute care cardiac policy, standards, and criteria, as reflected in the previous rule, together with an interim policy regarding the consider-

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ation of expansion of existing invasive cardiac laboratory resources through the certificate of need process. This interim policy permits applicants that document utilization levels greatly exceeding the threshold volume previously contained in these rules to seek relief through the certificate of need process.

The major policies contained in this chapter are summarized below:

1. Sections in each subchapter that establish cardiac data reporting requirements (at N.J.A.C. 8:33E-1.9 and N.J.A.C. 8:33E-2.10); peer review requirements (at N.J.A.C. 8:33E-1.5 and N.J.A.C. 8:33E-2.12); assurances of nondiscriminatory practices (at N.J.A.C. 8:33E-1.10 and N.J.A.C. 8:33E-2.11); and documentation of costs (at N.J.A.C. 8:33E-1.8 and N.J.A.C. 8:33E-2.9).

2. Sections in each subchapter which establish minimum annual utilization standards for the performance of cardiac diagnostic procedures (at N.J.A.C. 8:33E-1.3(b) and at N.J.A.C. 8:33E-2.3(c)), coronary angioplasty procedures and other therapeutic interventions (at N.J.A.C. 8:33E-2.3(d)), complex electrophysiology procedures (at N.J.A.C. 8:33E-2.3(e)) and open heart surgery cases (at N.J.A.C. 8:33E-2.3(a)).

3. Sections in both subchapters (at N.J.A.C. 8:33E-1.4 and at N.J.A.C. 8:33E-2.4) for the establishment of minimum professional credentials and staffing for the performance of cardiac catheterization, coronary angioplasty and other therapeutic interventions, complex electrophysiology studies (EPS) and open heart surgery.

4. A section in each subchapter (at N.J.A.C. 8:33E-1.3(f) and at N.J.A.C. 8:33E-2.3(c)5), which restricts the provision of cardiac catheterization services to hospital-based facilities where inpatient support services are immediately available on site.

5. Sections at N.J.A.C. 8:33E-2.3(d)3 and N.J.A.C. 8:33E-2.3(e)3, which restrict the provision of therapeutic interventions (for example, coronary angioplasty, directional coronary atherectomy, laser angioplasty, valvuloplasty) to hospital-based facilities where cardiac surgery services are immediately available on site.

6. Sections at N.J.A.C. 8:33E-1.13 and N.J.A.C. 8:33E-2.15 that establish the limited circumstances under which existing cardiac providers would be permitted to expand their invasive cardiac laboratory capacity.

**Social Impact**

N.J.S.A. 26:2H-1 (as amended) recognizes as "public policy of the State that hospitals and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of inhabitants of the State, promote the financial solvency of hospitals and similar health care facilities and contain the rising cost of health care services, the State Department of Health . . . shall have the central responsibility for the development and administration of the State's policy with respect to health planning, hospitals and health care services, and health facility cost containment programs . . ."

The Department of Health has historically recognized that the underutilization of inpatient beds, specialty services, and expensive equipment have been important factors contributing to the rapidly escalating costs of health care. Regionalization of specialty services and equipment is viewed as an important mechanism for promoting health by improving the capabilities of services and quality of care offered and for achieving cost efficiencies in the delivery of expensive and highly sophisticated health care services.

The regionalization of invasive cardiac diagnostic services, therapeutic cardiac intervention services, and cardiac surgery services is essential in generating caseloads of sufficient volume to maintain professional skills, thereby reducing unnecessary risks to patients and promoting the efficient and effective delivery of this specialized service.

As identified in the January 15, 1987 Cardiac Services Task Force report, "all evidence indicates that both quality of care, as reflected in mortality, and cost, as reflected in length-of-stay and physicians' fees, are influenced by the volume of procedures done by and the skill of the physician." The proposed chapter is important, therefore, for quality and cost reasons. The chapter promotes sufficient utilization at each adult and pediatric cardiac surgery center to maintain professional skills, thereby protecting patients from unnecessary risks. In addition, they inhibit the unrestricted growth of this service Statewide, thereby promoting appropriate utilization levels and insuring that the service is provided in a cost-efficient manner.

**Economic Impact**

The New Jersey Cardiac Services Task Force report indicated that total costs for cardiac services, particularly with respect to physician fees, are higher in New Jersey than in surrounding states. The provision of cardiac care services is becoming increasingly competitive, emphasizing the need to promote efficiencies in the delivery of these services. This proposed chapter establishes minimum utilization, staffing and professional credential requirements that are designed to promote high quality invasive cardiac diagnostic services, therapeutic cardiac intervention services, and open heart surgery services by assuring appropriate volume levels to maintain professional skills and provide an efficient and effective service. Since the cost of providing cardiac services is largely determined by spreading fixed costs over the number of cases performed, a cardiac service providing insufficient patient volumes represents a less than efficient use of a costly resource.

In the absence of these rules, the growth of new cardiac services would be unrestricted. To allow this to occur would be to encourage a reduction in the utilization of existing cardiac providers, offending quality of care considerations, and promoting significant cost inefficiencies in the provision of cardiac services throughout the State.

**Regulatory Flexibility Statement**

Since only large hospitals, having, by nature, well over 100 employees, would be capable of qualifying for a certificate of need for a cardiac diagnostic facility or a cardiac surgery center, no recordkeeping, reporting or other compliance requirements are placed upon small businesses by the proposed rules.

**Full text** of the proposed chapter follows:

8:33E-1.1 Scope and purpose

(a) The invasive cardiac diagnostic facility specializes in the detection and diagnosis of cardiac disorders. Unlike the cardiac surgery center in which both diagnostic and therapeutic services are co-located, the invasive cardiac diagnostic facility does not provide cardiac surgery but rather on the basis of diagnostic studies refers patients, where appropriate, to facilities offering cardiac surgery and other advanced cardiac diagnostic and treatment modalities. A regional approach to the provision of invasive cardiac diagnostic services is necessary to provide safe, complete patient care, efficiently and effectively, at reasonable cost to the consumer.

(b) In the invasive cardiac diagnostic facility the primary diagnostic services are provided by cardiac catheterization, coronary angiographic and non-invasive laboratories. The cardiac catheterization and coronary angiographic laboratories are devoted to achieving optimal quality physiological and angiographic studies. The non-invasive laboratory includes, at a minimum, ECG instruments, exercise stress testing, Doppler technology/echocardiography equipment and Holter type monitoring and nuclear cardiology (often in a separate department) facilities.

(c) The Inter-Society Commission for Heart Disease Resources (I.C.H.D.) and the New Jersey Cardiac Services Task Force support the position that the safety and efficacy of laboratory performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Death or serious nonfatal complications of myocardial infarction and/or cerebral embolus occurs in 1.5 percent of the population examined by invasive techniques. Such problems occur ten times more often in institutions performing fewer than 100 examinations per year than in those performing 400 examinations annually. In the interest of patient care, then, it is important to encourage maximum utilization of the State's existing diagnostic resources. It is also essential that in view of the invasive nature of the cardiac catheterization procedure and the extent of possible complications associated with these procedures, cardiac surgery services should be accessible promptly, either in-house or by immediate transfer, in the event of an emergency or complication. Therefore, outpatient catheterization must be performed in a laboratory that is physically part of a health care facility offering inpatient support services.

(d) The standards and criteria defined in this subchapter shall apply to the efficient delivery of quality diagnostic services within the setting of the cardiac catheterization laboratory. In addition to meeting these minimal requirements, the invasive cardiac diagnostic facility is expected to operate a well established non-invasive cardiac diagnostic laboratory. Additional policy has been proposed for the more comprehensive cardiac surgery center and is identified within N.J.A.C. 8:33E-2.

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8:33E-1.2 Definitions

For the purposes of this subchapter the following definitions shall apply:

"Cardiac catheterization" means the insertion of a thin, flexible tube (catheter) into a vein or artery and guiding it into the heart for purposes of diagnosis or limited treatment, such as the introduction of thrombolytic (clot dissolving) agents.

"Complex Electrophysiology Study" (EPS): Refers to the more complex variety of electrophysiology study (such as left atrial and ventricular mapping and ablation, catheter mapping, device implants and surgical procedures).

"Open heart surgery" refers to a procedure using a heart-lung by-pass machine to perform the functions of circulation during surgery.

"Pediatic" cardiac patients are those patients below the age of 16.

"Percutaneous transluminal coronary angioplasty" (PTCA) means the passage of a balloon-tipped catheter (thin tube) to the site of narrowing in an artery and the inflation of the balloon to reduce the obstruction. PTCA has come to include other invasive procedures to dilate coronary obstruction such as atherectomy of various kinds (for example, excisional, laser) and arterial stenting procedures.

8:33E-1.3 Utilization of invasive cardiac diagnostic facilities

(a) Utilization standards are based on the number of patients upon whom invasive cardiac diagnostic procedures (cardiac catheterization) are performed. Cardiac catheterization is characterized as the entry into the systemic circulation and catheterization of the right heart and especially the left heart or angiography of the cardiac structures.

(b) Volume of patients diagnosed is not the only determinant or indicator of quality. The provision of advanced and invasive cardiac procedures require appropriate institutional infrastructure, including specialized nursing services, sophisticated laboratory technology, and in some cases well-developed non-cardiac specialty expertise (See N.J.A.C. 8:33E-1.3 and 1.4). However, some minimum volume is required to maintain the skills of the diagnostic team and to minimize costs per patient. The minimum acceptable number of adult cardiac catheterization patients per cardiac laboratory is 500 per year in order to maintain the skills of the catheterization team and the efficiency and effectiveness of the invasive cardiac diagnostic service. New services must attain this minimum utilization level within three years of operation. Failure to achieve the minimum level by the end of the second year of operation will result in notification of Department of Health intention to withdraw Certificate of Need approval. The inability to achieve minimum utilization levels during the third year of operation will require the submission of a Certificate of Need to close the service. Existing services must achieve minimum utilization levels within one year of the effective date of this subchapter or be subject to administrative penalties.

(c) Applicants seeking to expand existing invasive cardiac diagnostic laboratory services must indicate conformance with all standards and criteria contained herein and document a minimum volume as defined at N.J.A.C. 8:33E-1.13 in the form of diagnostic catheterization procedures or cardiac catheterization equivalents (CEs) in the existing laboratory (or in each existing laboratory). A CE is considered to equal the average time required to perform a standard diagnostic cardiac catheterization. CEs for Percutaneous Transluminal Coronary Angioplasty (PTCA) (2.5 CEs) and initial (3.0 CEs) and repeat (1.5 CEs) Electrophysiology Studies (EPS) should be included if applicable.

(d) Each invasive cardiac diagnostic facility shall establish a minimum number of procedures for each physician with laboratory privileges in order to maintain a consistent level of proficiency within the laboratory. As recommended by the New Jersey Cardiac Services Task Force, in its 1987 report, each physician must perform 50 cases a year with a minimum of 100 cases over a two year period. (This minimum case load may be accomplished at more than one laboratory.)

(e) Only centers with invasive pediatric cardiac diagnostic and pediatric cardiac surgery programs shall perform invasive cardiac diagnostic procedures on pediatric patients.

(f) Cardiac catheterization procedures must be performed in a hospital-based facility where inpatient support services are available on site.

(g) The following shall apply to invasive cardiac diagnostic facilities providing or seeking to provide complex electrophysiology studies (EPS) or percutaneous transluminal coronary angioplasty (PTCA):

1. Complex electrophysiology studies and percutaneous transluminal coronary angiography as defined in N.J.A.C. 8:33E-1.2 shall be performed in a hospital-based facility where cardiac surgery services are immediately available on site.

8:33E-1.4 Facility personnel; requirements and responsibilities

(a) Each invasive cardiac diagnostic facility shall be staffed, at a minimum, by at least the following full-time personnel:

1. One physician;
2. One registered nurse; and
3. One technician.

(b) While the following functions shall be performed within each facility, more than one function may be executed by a single individual if that individual has been appropriately cross-trained to perform the required functions:

1. The laboratory director (physician in charge) shall be the chief diagnostician within the unit, and shall be certified by the Sub-Specialty Board of Pediatric Cardiology of the American Board of Pediatrics or the Cardiovascular Sub-Specialty Board of the American Board of Internal Medicine. In addition to Board certification, the director shall have broad experience and training in invasive cardiac diagnostic procedures, including, but not limited to, a minimum of 12 months in a cardiac catheterization training program and the performance of 200 cardiac catheterization procedures with 100 of these procedures performed as the primary operator.

2. Associate physicians may be assigned to the laboratory and shall meet the identical training and certification requirements for laboratory director contained in paragraph 1 above. In addition, all catheterizing physicians shall adhere to the minimum physician volume standards establised by each laboratory in accordance with N.J.A.C. 8:33E-1.2(d).

i. Exceptions for incumbent directors and associate physicians to these minimum training and certification requirements may be granted by the Commissioner upon application by an institution providing documentation as to the physician's qualifications, in accordance with the requirements of this chapter and N.J.A.C. 13:35.

3. The registered nurse shall assist with administration of medications and the preparation and observation of the patient. The nurse shall have (ICCU) experience, shall be competent in advanced life support (ALS), and must have knowledge of cardiovascular medications and experience with catheterization.

4. The cardiac catheterization technician shall handle blood samples and assist in the performance tests. The technician shall help in the maintenance of equipment and supplies and should be trained to aid in patient observation and acute cardiac care.

5. The monitoring and recording technician shall be responsible for constant monitoring of physiologic data including the electrocardiogram and recording this information. This function can best be handled by a second cardiac catheterization technician or radiologic technician.

6. The radiologic technician shall be skilled in conventional radiography and shall have special training and skills in angiographic techniques. This technician shall be competent in magnification radiography, subtraction photography, cine recording, television presentations and the use of video tape and shall be responsible for the care and maintenance of all radiologic equipment.

7. The electronic and radiological repair technician shall be highly trained and available for consultations regarding the operation and maintenance of all radiographic and physiologic measuring and re-

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cording instruments in the laboratory. This person shall be immediately available to carry out repairs in the event of equipment failures during the course of the procedure.

8. Hospitals providing invasive cardiac diagnostic services should, to the extent possible, have native speaking clinical personnel available who can overcome language barriers and know and understand cultural differences among patients.

9. Hospitals providing invasive cardiac diagnostic services shall develop cardiology outreach mechanisms and referral services (for example, physician education, public information, primary care clinical services).

(c) One physician trained and experienced in cardiac catheterization shall be present in the room during all catheterization and angiographic procedures. An appropriately trained and experienced registered nurse and technician shall also be present during all procedures.

8:33E-1.5 Peer review

(a) Quality control is essential for the consistent high quality level of performance required of any medical services. As one means of quality control, appropriate mechanisms for peer review shall be described in each application for designation as a cardiac diagnostic facility. Such mechanisms should include, but not be limited to, the delineation of criteria for the evaluation of:

1. Overall case selection for study (for example, rate of normal studies, rate of surgical referral);

2. Laboratory and physician performance as recommended by the Cardiac Service Task Force including the physician performance guidelines (for example, case volume, mortality and complication rates per physician);

3. Quality of studies (for example, number of incomplete studies, diagnostic adequacy of firms, number of restudies performed elsewhere);

(b) In all cases, criteria selection should be based on sound medical practice and consistency with the literature.

(c) Each peer review team shall include at least one cardiovascular surgeon from the surgical center to which surgical candidates are commonly referred.

8:33E-1.6 Commissioner's cardiovascular health advisory panel (CHAP)

(a) A cardiovascular health advisory panel shall be established, under the authority of the Commissioner of Health, to participate in the development of cardiovascular health policy. This committee shall also:

1. Assist in the development of Statewide cardiovascular health promotion and disease prevention activities;

2. Review cardiac service technological developments and the degree to which these developments have achieved clinical acceptance within the medical community;

3. Review State standards and criteria for cardiac services and Statewide cardiac service performance;

4. Respond to Statewide issues regarding cardiac care as requested by the Commissioner of Health;

5. Assist in the development and implementation of Statewide cardiac research and data activities.

8:33E-1.7 Association with cardiac surgical services

(a) Applicants providing cardiac diagnostic services without a surgery program shall have written agreements with institutions providing open heart surgery and catheterization, specifying a mechanism for insuring quality control, rapid referral for surgery, emergency back-up procedures and regular communication between the cardiologist performing catheterization and the surgeons to whom patients are referred. At least one of the referral agreements shall be written with a New Jersey cardiac center. In addition, one of the referral agreements shall be with a cardiac surgical center which is within one hour travel time from the diagnostic facility to insure prompt referral in the event of an emergency.

(b) To insure that costs are not unnecessarily increased by duplication of procedures, written assurance shall be included within the referral agreement stating that, to the greatest extent possible, the receiving facility will accept the results of the diagnostic facility's examinations. Departures from this practice shall be limited to an established peer review mechanism at the receiving center.

(c) The provision of complex electrophysiology services (EPS) and percutaneous transluminal coronary angiography (PTCA), as defined in this chapter, must be performed in a hospital-based facility where cardiac surgery services are immediately available on site.

8:33E-1.8 Documentation of purchase and operational cost

The applicant shall provide full written documentation of the projected implementation and operational costs of the proposed program. This documentation will include direct and indirect costs, that is, construction, equipment, supplies, personnel, maintenance, overhead costs, as well as projected costs of remodeling or renovation necessary to accommodate the program. Projections of anticipated revenues shall be supplied for at least the first three years.

8:33E-1.9 Statistical data required

At the request of the Commissioner, the facility shall maintain and provide basic statistical data on the operation of the program and report those data to the Department of Health on a quarterly basis and on a standardized form prepared by the Department. Copies of the full text of the required quarterly reporting forms may be obtained upon written request to the New Jersey State Department of Health, Center for Health Statistics, Room 405, CN 360, Trenton, New Jersey 08625.

8:33E-1.10 Certification of nondiscriminatory practices

Each applicant shall provide the Department with written certification of compliance with all Federal and State laws in regard to nondiscriminatory practices to the effect that no patient shall be refused treatment on the basis of race, religion, sex, age or ability to pay.

8:33E-1.11 Compliance

Facilities which are providing cardiac diagnostic services without cardiac surgery shall meet the minimum criteria and standards outlined in this subchapter within one year following the effective date of this subchapter, and each year thereafter, or be subjected to licensing sanctions. These sanctions may include closure of the service or that portion of the service that will result in compliance with minimum State standards.

8:33E-1.12 New facilities

(Reserved)

8:33E-1.13 Submission of Certificate of Need Applications

(a) The Department of Health will only process certificate of need applications for the expansion of existing invasive cardiac diagnostic facilities located in local advisory board areas, designated pursuant to the New Jersey Health Care Facilities Planning Act (P.L. 1971, c.136 and 138) and amendments thereto, and in accordance with procedures set forth below and in N.J.A.C. 8:33. Certificate of need applications will only be accepted for processing from existing cardiac catheterization providers located in local advisory board areas where all existing invasive cardiac diagnostic facilities and services meet minimum levels of utilization, per laboratory, as specified at N.J.A.C. 8:33E-1.3(b) and where the applicant's level of utilization during the most recent calendar year prior to submission of the application exceeds 1,800 diagnostic catheterization procedures. Documentation should also be provided that indicates that other existing area providers of this invasive cardiac diagnostic service will not be jeopardized by the proposed new service.

(b) No more than one additional invasive cardiac diagnostic laboratory expansion will be approved in each local advisory board area for each call for certificate of need applications.

SUBCHAPTER 2. REGIONAL CARDIAC SURGERY CENTERS

8:33E-2.1 Scope and purpose

(a) The purpose of this subchapter is to establish standards and general criteria for the planning of a regional cardiac surgical center and for the preparation of an application for a certificate of need

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for such a facility. A regional approach to the provision of cardiac services is necessary to provide safe, complete patient care, efficiently and effectively, at reasonable cost to the consumer.

(b) A regional cardiac surgical center is defined as a health care facility which specializes in most aspects of cardiac service, including at a minimum, cardiovascular surgical services as well as invasive cardiac diagnostic services. These cardiac surgery services are to be provided at a single hospital location.

(c) In the regional cardiac surgical center, the primary diagnostic services are provided by a cardiac catheterization and coronary angiographic laboratory and a non-invasive laboratory. A cardiac catheterization, coronary angiographic laboratory is one which provides a service devoted to achieving physiological and angiographic studies of optimal quality.

(d) At a minimum, the non-invasive laboratory shall include the following facilities:

1. ECG instruments;
2. Exercise Stress testing;
3. Echocardiography equipment;
4. Holter-type monitoring; and
5. Nuclear cardiology.

(e) Before heart surgery is performed, every patient shall undergo diagnosis through a recognized diagnostic service, except in an extreme emergency, as in the case of open wounds to the heart.

(f) The cardiovascular surgical services include open heart, closed heart and coronary artery surgery, as well as surgery of the great vessels, and also cardiac assist devices, such as the intra-aortic balloon pump. The requirements contained in this subchapter for facilities, personnel and equipment for open heart surgery shall be the minimum requirements for all cardiovascular surgical procedures.

8:33E-2.2 Definitions

For the purposes of this subchapter the following definitions shall apply:

"Cardiac catheterization" means the insertion of a thin, flexible tube (catheter) into a vein or artery and guiding it into the heart for purposes of diagnosis or limited treatment, such as the introduction of thrombolytic (clot dissolving) agents.

"Complex Electrophysiology Study" (EPS): Refers to the more complex variety of electrophysiology study (such as left atrial and ventricular mapping and ablation, catheter mapping, [ablation techniques,] device implants and surgical procedures).

"Open heart surgery" refers to a procedure using a heart-lung by-pass machine to perform the functions of circulation during surgery.

"Pediatric" cardiac patients are those patients below the age of 16.

"Percutaneous transluminal coronary angioplasty" (PTCA) means the passage of a balloon-tipped catheter (thin tube) to the site of narrowing in an artery and the inflation of the balloon to reduce the obstruction. PTCA has come to include other invasive procedures to dilate coronary obstruction such as atherectomy of various kinds (e.g., excisional, laser) and arterial stenting procedures.

8:33E-2.3 Utilization of cardiac surgical centers

(a) The following shall apply to adult cardiovascular surgical units:

1. Once criteria for new cardiac surgery services are developed at N.J.A.C. 8:33E-2.13 below, utilization criteria and standards for new cardiac surgery services will be specified and promulgated at that time.

2. All existing regional adult cardiac surgical centers shall continue to perform at least 250 open heart surgical procedures per year per operating room to insure the competency of the surgical services team and to provide for efficient and economical operation.

3. Existing regional adult cardiac surgery centers shall document a volume of 350 open heart surgical procedures per year per operating room in order to be considered for an expansion of its operating room capacity.

4. Existing regional adult cardiac surgery centers that are in compliance with all minimum standards and criteria contained in this subchapter, including the minimum volume requirements for percutaneous transluminal coronary angioplasty (PTCA) at (d) below, may utilize a separate operating room for PTCA backup. This backup operating room shall not be utilized for routine cardiac surgery and shall not be considered a cardiac operating room for purposes of this subchapter.

5. Each cardiac surgical center shall establish a minimum caseload per physician and team in order to ensure a consistent level of proficiency within the surgical program. As recommended in the Commissioner's Cardiac Services Task Force (CSTF) report, a minimum of 100 cases per year shall be maintained to preserve the professional skills of a supervising cardiac surgeon, which shall refer to the physician in charge of the specific case.

(b) The following shall apply to pediatric cardiac diagnostic and surgical services:

1. An applicant for a certificate of need as a regional pediatric cardiac surgical center shall provide written documentation that the proposed center will perform at least 150 pediatric open and closed heart surgery procedures per year, at least 75 of which must be open heart procedures, for each operating room utilized for pediatric open heart surgery by the end of the third year of operation and each year thereafter.

2. A regional pediatric cardiac surgical center shall continue to perform at least 150 pediatric open and closed heart surgery procedures per year per operating room to insure the competency of the pediatric surgical services team and to provide for an efficient and economical operation. Existing pediatric cardiac surgical centers shall achieve this utilization standard within one year of the effective date of this subchapter and shall maintain the standard on an annual basis thereafter.

3. The minimum acceptable number of pediatric cardiac catheterization patients per invasive pediatric cardiac diagnostic laboratory is 150 per year. New pediatric surgical centers shall achieve this minimum level of utilization in their invasive pediatric cardiac diagnostic laboratory within three years from the initiation of the service. As cited at N.J.A.C. 8:33E-1.2(e), pediatric patients requiring invasive cardiac diagnostic procedures shall undergo these procedures only in centers with invasive pediatric cardiac diagnostic and pediatric cardiac surgery programs.

4. Each invasive pediatric cardiac laboratory shall establish a minimum number of procedures for each physician with laboratory privileges in order to maintain a consistent level of proficiency within the laboratory. As recommended by the Commissioner's Cardiac Services Task Force (CSTF), a minimum of 50 pediatric cases a year with a minimum of 100 pediatric cases over a two year period shall be maintained to preserve a consistent level of proficiency.

(c) The following shall apply to adult cardiac diagnostic services located within the cardiac surgery center:

1. Utilization standards for the diagnostic services shall be based on the number of patients upon whom invasive cardiac diagnostic procedures are performed. The minimum acceptable number of adult cardiac catheterization patients per laboratory shall be 500 per year, in order to maintain the efficiency and the skills of the catheterization team.

i. Each invasive cardiac diagnostic service shall establish a minimum number of procedures for each physician with laboratory privileges in order to maintain a consistent level of proficiency within the laboratory. As recommended by the Commissioner's Cardiac Services Task Force (CSTF), a minimum of 50 cases a year with a minimum of 100 cases over a two year period must be maintained to preserve a consistent level of proficiency.

2. Surgical centers seeking to expand existing invasive cardiac diagnostic laboratory services must indicate conformance with all standards and criteria contained in this subchapter and document a minimum volume of cardiac catheterization procedures or cardiac catheterization equivalents (CEs) in the existing laboratory (or in each existing laboratory) as specified at N.J.A.C. 8:33E-2.15. A CE is considered to equal the average time required to perform a cardiac catheterization procedure. A percutaneous transluminal coronary angioplasty procedure will be considered as 2.5 CEs. An initial complex electrophysiology study will be 3.0 CEs and a repeat complex electrophysiology study will be 1.5 CEs.

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3. The laboratory must be prepared to perform pre- and post-operative examinations on a scheduled basis, and emergency examinations at all times.

4. As a planning guideline, the accepted ratio of examinations to cardiac operations shall be at least two examinations to one operation.

5. Cardiac catheterization procedures must be performed in a hospital-based facility here inpatient support services are available on site.

(d) The following shall apply to adult cardiac surgery centers providing or seeking to provide percutaneous transluminal coronary angioplasty (PTCA) services:

1. An applicant for a certificate of need as a regional adult cardiac surgery center that also seeks to provide PTCA services in its invasive cardiac diagnostic laboratory must provide written documentation that the center will perform a minimum of 200 PTCA procedures per year by the third year of operation.

2. A regional adult cardiac surgery center shall continue to perform a minimum of 200 PTCA procedures annually in order to assure acceptable institutional quality. Existing cardiac surgery centers providing PTCA shall comply with this utilization standard within this one year of the effective date of this subchapter and shall maintain this standard on an annual basis thereafter.

3. PTCA procedures must be performed in a hospital-based facility where cardiac surgery services are immediately available on site.

4. Each PTCA facility shall establish a minimum number of PTCA procedures for each physician with PTCA laboratory privileges. As recommended by the Commissioner's Cardiac Services Task Force (CSTF), each physician seeking to continue to perform PTCA procedures as the primary operator shall perform a minimum of 75 PTCA cases a year, 150 PTCA cases over a two year period (excluding the physician's first year of clinical practice following completion of training), and 50 PTCA cases per year, as primary physician, to preserve a consistent level of proficiency.

(e) The following shall apply to adult cardiac surgery centers providing or seeking to provide complex electrophysiology studies (EPS):

1. An applicant for a certificate of need as a regional adult cardiac surgery center that also seeks to provide complex electrophysiology studies or an existing cardiac surgery center seeking to initiate complex electrophysiology services must provide written documentation that the center will perform a minimum of 100 electrophysiology studies per year, with at least 50 of these studies representing initial studies of patients. These new complex electrophysiology services must achieve this minimum utilization level within three years of service implementation.

2. A regional cardiac surgery center shall continue to perform a minimum of 100 complex electrophysiology studies annually in order to assure acceptable institutional quality. Existing cardiac surgery centers providing complex electrophysiology studies shall comply with this utilization standard within one year of the effective date of this subchapter and shall maintain this standard on an annual basis thereafter.

3. Complex electrophysiology studies shall be performed in a hospital-based facility where cardiac surgery services are immediately available on site.

4. Each complex electrophysiology service shall establish a minimum number of complex electrophysiology studies for each physician with electrophysiology laboratory privileges. As recommended by the Commissioner's Cardiac Services Task Force (CSTF), a minimum of 50 complex electrophysiology cases a year, with at least 25 as initial studies, shall be maintained to preserve a consistent level of proficiency.

8:33E-2.4 Cardiac surgery center personnel

(a) The following shall apply to cardiovascular surgical units:

1. Cardiac surgery is most successful when performed by a smoothly functioning team. Based on 250 open heart procedures the basic team of the regional cardiac surgical center for each operation shall consist of the following permanently assigned staff:

i. One physician in charge, board-certified by the American Board of Thoracic and Cardiovascular Surgery as a cardiovascular surgeon who directs the team or the surgical unit. Based on the Commissioner's Cardiac Task Force recommendation, the physician in charge must perform a minimum of 100 procedures annually;

(1) Exceptions for incumbent directors to this requirement for board certification may be granted by the Commissioner after consultation with the CCSC and upon application by an institution providing proper documentations as to the physician's qualifications;

ii. One assistant to the physician in charge who will be a board qualified surgeon. A cardiothoracic surgery resident or fellow may serve as an assistant. There shall be two surgeons in the operating room;

iii. A board certified anesthesiologist with additional training and experience in cardiac surgery problems shall be responsible for the anesthetic management of cardiac surgery patients. This anesthesiologist may be assisted by another board certified or board eligible anesthesiologist, an anesthesia resident, an anesthesia technician, or a nurse anesthetist with special training and experience with cardiac surgery patients;

iv. There shall be at least two operating room nurses (at least one of whom must be a registered nurse) trained and experienced in cardiac surgery and advanced cardiac life support in each operating room;

v. One certified perfusionist (a trained and qualified perfusionist who is currently part of a cardiac surgery team may be included) shall operate the perfusion pump. A second individual capable of handling the pump should be available to assist this perfusionist as the need arises. Certification of all perfusionists is recommended;

vi. A cardiovascular nurse specialist (one for every 100 open heart procedures) may be employed to supplement the cardiovascular surgical team.

vii. A board certified cardiologist shall be available to assist in the management of problems relating to unstable hemodynamic status and complex arrhythmias, if necessary.

2. The operating cardiac surgeon, in conjunction with the attending cardiologist, shall be responsible for overseeing and integrating all details of pre-operative evaluation and preparation of the operation procedures and of postoperative care.

(b) The intensive care cardiac recovery room (or Surgical Critical Care Unit, (SCCU) is the area where cardiac patients are held for postoperative care. At a minimum, patient coverage in this area shall be on a one specially trained cardiac nurse to one patient basis for the first 24 hours after surgery or in accordance with the diagnosis. During this period, the operating surgeon and team or qualified alternate shall be on call. After a full 24 hours following the operative day, and in accordance with patient diagnosis, nursing coverage may be reduced to a maximum of three patients to two nurses during the second and third days following the operative day as long as ventilatory and other life support systems have been discontinued.

1. There should be at least six surgical intensive care beds for each operating room within the surgical center that is dedicated to open heart surgery patients.

2. The surgical intensive care unit shall include physiologic monitoring equipment capable of arrhythmia detection (including slave scopes). Portable x-ray equipment and computers for laboratory work should also be available.

(c) The following shall apply to cardiac diagnostic facilities located in a cardiac surgery center:

1. Each diagnostic facility shall be staffed, at a minimum, by the following full-time personnel:

i. One physician;

ii. One registered nurse; and

iii. One technician.

2. While the following functions shall be performed within each facility, more than one function may be executed by a single individual who has been appropriately cross-trained to perform the required functions:

i. The laboratory director (physician in charge) shall be the chief diagnostician within the unit, certified in cardiology by the Sub-Specialty Board of Pediatric Cardiology of the American Board of Pediatric or the Cardiovascular Sub-Specialty Board of the American Board of Internal Medicine. In addition to board certification, the

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director shall have broad experience and training in invasive cardiac diagnostic procedures including, but not limited to, a minimum of 12 months in a cardiac catheterization training program and the performance of 200 cardiac catheterization procedures with 100 of these procedures performed as the primary operator;

ii. Associate physicians may be assigned to the laboratory and shall meet the identical training and certification requirements for laboratory director contained in (c)2i above. In addition, all catheterizing physicians must adhere to the minimum physician volume standards established by each laboratory in accordance with N.J.A.C. 8:33E-2.3(c);

(1) Exceptions to these minimum training and certification requirements for incumbent directors and associate physicians may be granted by the Commissioner after consultation with the CHAP and upon application by an institution providing proper documentation as to the physician's qualifications, in accordance with the requirements of this chapter and N.J.A.C. 13:35.

iii. The registered nurse shall assist with administration of medications and the preparation and observation of the patient. The nurse shall have Intensive Care Cardiac Unit (ICCU) experience, competence in advanced cardiac life support (ALS), and must have knowledge of cardiovascular medications and experience with catheterization;

iv. The cardiac catheterization technician shall handle blood samples and assist in the performance tests. The technicians shall help in the maintenance of equipment and supplies;

v. The monitoring and recording technician shall be responsible for constant monitoring of physiologic data, including the electrocardiogram, and recording this information. This job can best be handled by a second cardiac catheterization technician or radiologic technician;

vi. The technician shall be skilled in conventional radiography and shall have special training and skills in angiographic techniques. This technician shall be competent in magnification radiography, subtraction photography, cine recording, television presentations and the use of video tape and be responsible for the care and maintenance of all radiologic equipment;

vii. The electronic and radiological repair technician shall be highly trained and available for consultations regarding the operation and maintenance of all radiographic and physiologic measuring and recording instruments in the laboratory. This person shall be immediately available to carry out repairs in the event of equipment failures during the course of the procedure;

viii. Hospitals providing invasive cardiac diagnostic and cardiac surgery services shall, to the extent possible, have native speaking clinical personnel available who can overcome language barriers and know and understand cultural differences among patients; and

ix. Hospitals providing invasive cardiac diagnostic and cardiac surgery services should develop cardiology outreach mechanisms and referral services (for example, physician education, public information, primary care clinical services).

3. One physician trained and experienced in cardiac catheterization shall be present in the room during all catheterization and angiographic procedures. A nurse and a technician, trained and experienced as required by this chapter, shall be present during all procedures.

(d) Only the special personnel required by a cardiac diagnostic center established within an existing hospital are specified in (c) above. Appropriate supporting staff or personnel shall be available in existing departments within the hospital, in accordance with the requirements of all applicable laws, rules and regulations.

(e) The following shall apply to invasive cardiac diagnostic facilities located in cardiac surgery centers that seek to perform percutaneous transluminal coronary angioplasty (PTCA):

1. Each invasive diagnostic facility must be staffed, at a minimum, by the following personnel during a PTCA procedure:

i. The physician directing the procedure shall be a board certified cardiologist with well-recognized excellence in the management of routine cardiac catheterization and who has participated in a minimum of 100 PTCA procedures (with at least 50 as primary operator);

ii. An assisting physician may be a board eligible cardiologist or a cardiology fellow;

iii. A registered nurse trained and experienced in advanced life support, cardiac drugs, and cardiac catheterization/PTCA shall be available to assist with PTC procedures; and

iv. A radiologic technician trained and experienced in cardiac catheterization/PTCA shall be available to assist with PTCA procedures.

(f) The following shall apply to invasive cardiac diagnostic services located in cardiac surgery centers that seek to perform complex electrophysiology studies (EPS):

1. Each invasive cardiac diagnostic service shall be minimally staffed, at a minimum, by the following personnel during a complex electrophysiology study:

i. The physician directing the procedure must be a board certified cardiologist with well-recognized excellence in the management of routine cardiac catheterization who has obtained at least one additional year of specialized training in complex EPS and cardiac arrhythmias, including participation in 100 complex EPS procedures.

ii. An assisting board certified cardiologist shall be present during complex EPS procedures.

iii. A registered nurse trained and experienced in advanced life support, cardiac drugs, and cardiac catheterization/EPS shall be present during the procedure.

iv. A radiologic technician trained and experienced in cardiac catheterization/EPS shall be present during the procedure.

8:33E-2.5 Use of inpatient facilities

(a) In a center performing 250 open heart surgical procedures annually, the following inpatient facilities shall be required:

1. Because of the nature of care to be provided, cardiac surgical patients shall be grouped at the intermediate or acute care level for proper observation and treatment. During the preoperative stage when diagnostic work-ups are to be performed, six beds in a general medical/surgical unit shall be available for patients having an average length of stay of three to four days.

2. An intermediate intensive care/cardiac care unit will be available for post-operative care. It shall include four beds for patients having an average length of stay of three to four additional days following discharge from the SCCU or surgical recovery room. These beds may be located in a cardiovascular step-down unit with telemetry monitoring but reduced nursing coverage with a maximum ratio of four patients to one nurse in accordance with patient diagnosis. Suitably equipped beds will be available for the rest of the patient's stay. At a minimum the intensive care/cardiac care unit will have the following capabilities:

i. Facilities for hemodynamic ECG monitoring;

ii. Temporary pacemaker insertion;

iii. C.P.R. equipment;

iv. Arrhythmia detection equipment;

v. Resuscitative equipment; and

vi. Cardiovascular support devices (such as an intra-aortic balloon pump).

8:33E-2.6 Commissioner's cardiovascular health advisory panel (CHAP)

(a) A cardiovascular health advisory panel shall be established, under the authority of the Commissioner of Health, to participate in the development of cardiovascular health policy. This committee shall also:

1. Assist in the development of Statewide cardiovascular health promotion and disease prevention activities;

2. Review cardiac service technological developments and the degree to which these developments have achieved clinical acceptance within the medical community;

3. Review State standards and criteria for cardiac services and Statewide cardiac service performance;

4. Respond to Statewide issues regarding cardiac care, as requested by the Commissioner of Health;

5. Assist in the development and implementation of Statewide cardiac research and data activities.

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8:33E-2.7 Referral

(a) Each applicant for a certificate of need as a regional cardiac center shall agree to send out a mailing to all appropriate institutions and physicians stating that the services of the center are available. Following certificate of need approval, the center shall provide the Department with written documentation that this mailing has occurred.

(b) Each applicant shall provide written documentation, in the form of an institutional policy statement, that the center will accept referrals from physicians not ordinarily having access to the applicant's facilities.

(c) Each center will have written transfer agreements to receive appropriate patients from the invasive cardiac diagnostic facilities in its service area, or health services area, whichever is larger.

8:33E-2.8 Population base

(Reserved)

8:33E-2.9 Documentation of purchase and operational cost

The applicant will provide full written documentation of the projected implementation and operational costs of the proposed program. This documentation will include direct and indirect costs, that is, construction, equipment, supplies, personnel, maintenance, overhead costs, as well as projected costs of remodeling or renovation necessary to accommodate the program. Projections of anticipated revenues shall be supplied for at least the first three years.

8:33E-2.10 Statistical data required

At the request of the Commissioner, the facility will maintain and provide basic statistical data on the operation of the program and report that data to the Department of Health on a quarterly basis and on a standardized form prepared by the Department. Copies of the full text of the required quarterly reporting forms may be obtained upon written request to the New Jersey State Department of Health, Center for Health Statistics, Room 405, CN 360, Trenton, New Jersey 08625.

8:33E-2.11 Certification of nondiscriminatory practices

Each applicant shall provide the Department with written certification of compliance with all Federal and State laws in regard to nondiscriminatory practices to the effect that no patient shall be refused treatment on the basis of race, religion, sex, age or ability to pay.

8:33E-2.12 Peer review

(a) Quality control is essential for the consistent high quality level of performance required of any medical services. As one means of quality control, appropriate mechanisms for peer review shall be described in each application for designation as a cardiac diagnostic facility. Such mechanisms should include, but not be limited to, the delineation of criteria for the evaluation of:

1. Overall case selection for study (for example, rate of normal studies, rate of surgical referral);

2. Laboratory and physician performance as recommended by the Cardiac Service Task Force including the physician performance guidelines (for example, case volume, mortality and complication rates per physician);

3. Quality of studies (for example, number of incomplete studies, diagnostic adequacy of firms, number of restudies performed elsewhere);

(b) In all cases, criteria selection should be based on sound medical practice and consistency with the literature. Cardiac surgical centers with marginal utilization (10 percent above or below minimum utilization standards) will be reviewed by the CHAP to assure appropriate case selection has occurred.

8:33E-2.13 New facilities

(Reserved)

8:33E-2.14 Compliance

(a) Existing pediatric and adult cardiac surgery centers shall continue to meet the minimum criteria and standards contained in this subchapter on an annual basis. Existing providers failing to achieve minimum utilization standards specified in this subchapter within one year following the effective date of this subchapter and each year thereafter will be subject to reimbursement or licensing sanctions. These sanctions may include closure of the service or that portion of the service that will result in compliance with minimum State standards.

(b) All certificate of need applications for new pediatric and adult cardiac surgery centers must document the ability of the applicant to meet the minimum standards and criteria contained in this subchapter within three years from the initiation of the service. Failure to achieve the minimum level by the end of the second year of operation will result in notification of Department of Health intention to rescind certificate of need approval and more for licensing sanctions. The inability to achieve minimum utilization levels during the third year of operation or thereafter will result in loss of license for the service.

8:33E-2.15 Submission of Certificate of Need applications

(a) The Department of Health will only process certificate of need applications for the expansion of existing invasive cardiac diagnostic services within cardiac surgery centers located in local advisory board areas, designated pursuant to The New Jersey Health Care Facilities Planning Act (P.L. 1971, c.136 and 138) and amendments thereto, in accordance with procedures set forth below and in N.J.A.C. 8:33. Certificate of need applications will only be accepted for processing from existing cardiac catheterization providers located in local advisory board areas where all existing invasive cardiac diagnostic facilities and services meet minimum levels of utilization per laboratory during the most recent calendar year prior to submission of the application as specified at N.J.A.C. 8:33E-1.3(b) or at N.J.A.C. 8:33E-2.3(c), whichever is applicable; and where the applicant's level of utilization during the most recent calendar year prior to submission of the application exceeds 2,500 catheterization equivalents per laboratory. Documentation should also be provided that indicates that other existing area providers of this invasive cardiac service will not be jeopardized by the proposed new service.

(b) No more than one additional invasive cardiac diagnostic laboratory expansion will be approved in each local advisory board area for each call for certificate of need applications.

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# (a)

## OFFICE OF HEALTH POLICY AND RESEARCH

## Certificate of Need Policy Manual for Long-Term Care Services

## Proposed Amendments: N.J.A.C. 8:33H

Authorized By: Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with the approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5 and 8; P.L. 1992, c.160.

Proposal Number: PRN 1993-445.

Submit comments by September 15, 1993 to:
Nancy Moyer, Ph.D.
Office of Health Policy and Research
New Jersey Department of Health
CN 360
Trenton, New Jersey 08625

The agency proposal follows:

**Summary**

Over the past 18 months, the Department of Health has undertaken a number of initiatives aimed at restructuring the State's long-term care system. These initiatives are intended to give consumers a greater choice of cost-effective home and community-based alternatives to nursing home care. Thus, one purpose of the proposed amendments is to introduce certificate of need review criteria for two new long-term care options which have been developed as part of this reform effort: assisted living residences and comprehensive personal care homes. The licensing standards for these health care facilities are proposed as new rules at N.J.A.C. 8:36, published elsewhere in this issue of the New Jersey Register.

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The Department of Health is proposing amendments to N.J.A.C. 8:33H which reflect a new approach to planning, consistent with the goal of creating a better balanced long-term care system. This approach calls for an 18 month "window of opportunity" allowing for the expedited certificate of need review of applications for assisted living residences and comprehensive personal care homes. In this manner, the development of long-term care services that substitute for nursing home placement will be encouraged.

The proposed amendments have been developed with the generous assistance of two advisory groups established by the Department of Health: the Long-Term Care Overview Panel and the Assisted Living Policy Work Group. The Overview Panel is a 22-member committee that includes representation by consumers, long-term care industry representatives, health and social service providers, the State's six Local Advisory Boards, and governmental agencies (Department of Human Services—Medicaid; Department of Treasury—Office of Management and Budget; and Department of Community Affairs—Division on Aging). This group has been responsible for assisting the Department of Health in formulating the direction long-term care planning should take in New Jersey. They recommended that the Department of Health implement the "window of opportunity" described above.

The Assisted Living Policy Work Group has 19 members representing the nursing home and residential health care industries, health care professionals, and governmental agencies (Department of Human Services—Medicaid; Department of Community Affairs—Division on Aging). This Policy Work Group assisted the Department of Health in developing the licensing standards and certificate of need criteria for comprehensive personal care homes and assisted living residences.

The proposed amendments to N.J.A.C. 8:33H include a number of other changes to bring the rules into conformance with the Health Care Reform Act of 1992 (P.L. 1992, c.160). This Act exempts several types of health care facilities from Certificate of Need, including adult day health care programs, continuing care retirement communities, and changes in residential health care facility services (excluding, of course, conversions to other licensing categories such as comprehensive personal care, in which case a certificate of need will be required). Certificate of need criteria for each of these are currently contained in N.J.A.C. 8:33H; the amendments will result in their elimination.

Major proposed changes include the following:

1. N.J.A.C. 8:33H-1.1(a) is deleted, removing the reference to N.J.A.C. 8:100. The latter was invalidated as rules by virtue of the Appellate Division's decision in *In the Matter of the Adoption of Regulations Governing the State Health Plan, N.J.A.C. 8:100,* 262 *N.J. Super.* 469 (App. Div. 1993). A new statement of purpose is proposed in its place.

2. In N.J.A.C. 8:33H-1.1(c), services which are no longer subject to certificate of need review (per the Health Care Reform Act of 1992, P.L. 1992, c.160) are deleted. The Act exempts the following long-term care-related facilities from certificate of need: changes in residential health care facility services, continuing care retirement communities, adult day health care facilities, and pediatric day health care facilities. New licensing categories which will require a certificate of need are added to N.J.A.C. 8:33H-1.1(c). These are comprehensive personal care homes and assisted living residences.

3. Changes to the "Definitions" section are proposed in N.J.A.C. 8:33H-1.2. Newly defined terms include "aging in place," "ACCAP," "assisted living," and "nursing home-level care needs." The definitions of several other terms have been modified, including the definition of "alternate family care," "assisted living residence," "CCPED," "Comprehensive Personal Care Home," "deficiency," "statewide restricted admissions facility," and "continuing care retirement community" (CCRC). "Deficiency" is amended to delete the reference to the Office of Administrative Law, since it is the Commissioner of Health who would make the final decision in an appeal process. "Statewide restricted admissions facility" has been modified to delete religiously affiliated nursing facilities, since these have been exempted from certificate of need with the 1993 passage of S-205. CCRCs have also been exempted from certificate of need, and the proposed amendment clarifies their definition. Finally, the definition of an "adult day health care program" is deleted from 8:33H-1.2, since the service is now exempted from certificate of need.

4. N.J.A.C. 8:33H-1.3 has been recodified to N.J.A.C. 8:33H-1.20 and modified to incorporate by reference the newly proposed licensing standards for assisted living residences and comprehensive personal care homes. Reference to the licensing standards for adult day health care facilities is deleted. At N.J.A.C. 8:33H-1.3, the Department proposes a new section entitled, "Window of opportunity approach to planning long-term care alternatives." This section explains that there will be an 18-month opportunity for alternatives, including assisted living residences and comprehensive personal care homes, to receive an expedited certificate of need review.

5. N.J.A.C. 8:33H-1.4 and 1.5 contain amendments which are consistent with other changes in the chapter. In N.J.A.C. 8:33H-1.4(b) and (d), adult day health care is eliminated from the range of options to be considered by county long-term care committees in formulating a placement mix proposal. Changes in N.J.A.C. 8:33H-1.5(d)2 reflect the fact that licensing and certificate of need standards for assisted living residences and comprehensive personal care homes are to be adopted, and a facility's licensing or certificate of need approval status will thus be used in counting the supply of long-term care placements.

6. N.J.A.C. 8:33H-1.6(d), which contains requirements for pediatric day health care programs, is proposed for deletion. This is consistent with the mandate of P.L. 1992, c.160.

7. The section containing certificate of need requirements for adult day health care programs, N.J.A.C. 8:33H-1.8, is proposed for repeal (see paragraph 2 above). In its place, requirements for the expedited review of assisted living residences are proposed.

8. N.J.A.C. 8:33H-1.10, which contains the requirements for continuing care retirement communities, is proposed for repeal (see paragraph 2 above). In its place, requirements for the expedited review of comprehensive personal care homes are proposed.

9. N.J.A.C. 8:33H-1.12 and 1.13 have been modified to bring them into compliance with P.L. 1992 c.160. Thus, requirements for the expansion or reduction of beds in a residential health care facility, or the closure of a residential health care facility, are eliminated.

10. N.J.A.C. 8:33H-1.14 has been modified to indicate that quality care and licensure track record requirements will apply to applicants for assisted living residences and comprehensive personal care homes.

11. N.J.A.C. 8:33H-1.18, location of facilities, has been modified so that the requirements will apply generically to all new facilities which are covered under the provisions of this chapter.

**Social Impact**

The proposed amendments should result in the development of a more diverse array of high quality long-term care options, greater consumer choice, and an improved quality of life for those who need long-term care. While these rules will not lead to the creation of more in-home services, which are often the most preferred form of care for the majority of disabled people, they will nonetheless address the pressing needs of those who are no longer capable of living in their own homes. Apart from the amendments proposed herein, but consistent with the Department of Health's long-term care system reform efforts, the Department of Human Services is making an expanded number of home care slots available in Medicaid's Community Care Program for the Elderly and Disabled this year.

New Jersey's long-term care system is skewed in favor of nursing home care, offering a limited range of alternatives. This is in part the result of past planning and certificate of need policies which, in response to growth in the disabled and elderly populations, encouraged expansion of the nursing home bed supply, but did little to foster the creation of other viable options. Between 1983 and 1991, the Department of Health approved the construction of 18,538 new nursing home beds. Currently there are approximately 48,000 licensed long-term care facility beds, plus 4,400 certificate of need-approved but not yet licensed beds in New Jersey. Additionally, the Department is reviewing applications submitted in October 1992, with the intent of approving 1,100 more nursing home beds. The proposed amendments are designed to remedy this institutional bias.

Assisted living residences will generally be newly constructed buildings that offer residents benefits which are presently unavailable in any other type of health care facility. A personally furnished, apartment-style living environment and a uniquely individualized approach to care are intended to promote residents' sense of autonomy, privacy, and self-esteem. Proposed certificate of need review requirements assure that applicants have a clear vision of assisted living and are capable of implementing the concept in their projects.

Comprehensive personal care homes will be created primarily through the voluntary conversion of existing residential health care facilities (RHCFs) and Class C boarding homes. Currently, there are approximately 11,000 RHCF beds and 4,800 Class C boarding home beds in the State. These facilities typically offer shared-occupancy rooms and a limited amount of personal care assistance; they are primarily occupied

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by the frail elderly and/or adults with mental illness. By deciding to convert to a comprehensive personal care home (CPCH), the facility will be able to offer assisted living services, including nursing care, for residents who need it, without having to undertake costly physical plant modifications.

Although CPCHs will not offer apartment units as will be required for assisted living residences, they will nonetheless provide needed care based on the assisted living model. This represents a pragmatic use for a currently under-utilized health care resource (Statewide occupancy rates in RHCFs and Class C Boarding Homes average about 70 percent and 60 percent, respectively). Because the comprehensive personal care home setting is viewed as more institutional and less homelike than the assisted living residence, new construction of additional CPCHs will not be encouraged. Certificate of need requirements for CPCH have been framed to allow conversions, with exceptions to permit small bed additions and the new construction of inpatient hospice facilities.

A highly beneficial feature of both new alternatives will be the opportunity for residents to "age in place." To the greatest extent possible, residents in comprehensive personal care homes and assisted living residences will be able to receive additional services as their long-term care needs increase, without having to relocate to another facility or to a different room in the same facility. Thus, assisted living residences and comprehensive personal care homes are expected to serve a mix of people ranging from those who are fairly independent and high functioning to those with nursing home-level care needs.

By contrast, current licensing standards for so-called "lower level alternatives" to nursing homes are restrictive in ways that create anguishing dilemmas for residents whose disabilities and needs for assistance increase over time. For example, a person living in a residential health care facility or Class C boarding home who develops impaired mobility, incontinence, or increased dementia must generally leave the facility. In this way, residents lose their ability to function and, at the same time, their home. This double loss often fosters a sense of helplessness and despair. Aging in place should address this problem, increasing residents' well-being. In addition, it will improve utilization of already existing facilities.

Certificate of need applicants for comprehensive personal care homes and assisted living residences should benefit from the proposed 18-month "window of opportunity," during which they will receive an expedited review. Their projects will not be subject to a need methodology, and they will not have to compete to fill a capped need for placements in any particular county.

A thorough review of applicants' history of providing quality care will be required as part of the expedited certificate of need process. This screening will have a beneficial social impact in precluding the development of assisted living residences and comprehensive personal care homes by applicants with a poor licensing track record.

Given the Department's desire to stimulate development of the alternatives, and in view of the general uncertainty about how best to determine need for these new types of facilities, the expedited review process is deemed to be most appropriate at this time. The complexity of projecting need for comprehensive personal care homes and assisted living residences stems from the fact that many residents will age in place. A constantly changing number of each facility's residents will have health care needs of varying degrees; some people are likely to occupy rooms or apartments in these settings for years before they reach the point of requiring nursing home-level care provided by the facility.

Capping the number of slots using a formula similar to the existing need methodology at N.J.A.C. 8:33H-1.5 might have the unfortunate effect of forcing some residents to be displaced from CPCHs and assisted living residences at the time that they develop the need for nursing home-level care. For example, if a county has 100 slots allocated for nursing home-level care in comprehensive personal care homes, and 120 residents of these facilities require care, 20 of them might technically have to be relocated to some other type of facility, such as a nursing home. This would defeat the goal of aging in place.

Notwithstanding the aforementioned concerns, it is the Department of Health's position that there are over-arching benefits to controlling the supply of long-term care placements through a need methodology. In the next 18 months, the Department will carefully monitor the development and utilization of comprehensive personal care homes and assisted living residences, as well as other long-term care services. The aim will be to devise a new need formula that will assure access to needed care and the opportunity to age in place, without generating a wasteful surplus of poorly utilized facilities.

The benefits of new long-term care alternatives will only be realized if people know how and when to access them. The Department of Health will continue to work with its advisory committees (for example, the Long-Term Care Overview Panel) and other State agencies to educate the public about assisted living residences and comprehensive personal care homes, and to shape a well coordinated, efficient, easily accessible long-term care system in New Jersey. Furthermore, other alternatives such as assisted living programs in publicly subsidized senior housing and alternate family care programs will be proposed as they are developed by the Department in consultation with its working committees.

**Economic Impact**

It is anticipated that the creation of lower cost alternatives to nursing home placement will benefit many consumers who seek more affordable options. Ultimately, the availability of comprehensive personal care homes and assisted living residences should also benefit the State with cost savings, if those who are dependent on Medicaid are able to access these less costly services as substitutes for nursing home care. Currently, approximately 65 percent of all nursing home patients are Medicaid recipients. The Department of Human Services is committed to the concept of creating additional alternatives to nursing facility care, and the Divison of Medical Assistance and Health Services (Medicaid) is dedicated to the development of cost-effective options for the Medicaid-eligible population.

It is difficult to know precisely how the cost of alternatives and nursing home care will compare in New Jersey. The experience in other states has demonstrated that assisted living is less costly than nursing facility services. While the relatively spacious, homelike, apartment-style construction of new assisted living residences is likely to be expensive, operational savings can be achieved due to the flexible staffing requirements and the fact that residents will furnish their own apartments. Because comprehensive personal care homes do not entail new construction and will not typically offer the amenities found in assisted living residences, it is expected that their rates will be lower. Regardless of the physical setting, the assisted living model emphasizes self-care, neighborly interaction between residents, and family participation in care; these factors should result in less reliance on costly facility staff and formal services than would be expected in a nursing facility.

One recently constructed assisted living facility in another state offering a level of care similar to that proposed for New Jersey's assisted living residences charges $1,500 per month for a one bedroom apartment, plus $275.00 to $650.00 for board and care (1991 rates). Other providers have quoted all-inclusive monthly rates for assisted living in the $2,000 to $2,500 range. By contrast, private pay rates for nursing homes average over $3,000 per month. Since assisted living facilities house people with a variety of needs for assistance, many have graduated rate schedules depending on the intensity services to be provided.

Medicaid's current net costs (minus available patient income) are approximately $2,500 per month, or $30,000 per year, for nursing home care in New Jersey. This includes payment for the patient's room, board, and care, as well as reimbursement for the facility's capital costs. In paying for the alternatives, Medicaid will reimburse the patient's personal care and health service costs; residents will be responsible for paying their own room and board charges in a comprehensive personal care home or assisted living residence. For example, low income people could use their Supplemental Security Income to pay for their room and board, while Medicaid would pay for their personal care and health services. In fiscal year 1994, Medicaid will have a limited number of placements available for care in the proposed alternative settings.

The amendments are expected to have a beneficial impact on the New Jersey economy. The new assisted living industry that will result from the adoption of these rules and N.J.A.C. 8:36 will spur the creation of many jobs for those who will design, construct, operate, and staff assisted living residences throughout New Jersey. Comprehensive personal care homes will most likely need to hire additional nursing and personal care staff, increasing job opportunities in these settings.

**Regulatory Flexibility Analysis**

Certificate of need applicants that will be affected by these amendments may include some small businesses employing fewer than 100 persons, such as real estate development companies, small residential health care facilities, or consulting firms. It is difficult to project how many small businesses will be affected, since assisted living residences and comprehensive personal care homes will be brand new categories of facilities; perhaps 50 small businesses will apply during the proposed 18-month "window of opportunity" described in N.J.A.C. 8:33H-1.3. In

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order to assure the orderly development of high quality long-term care services and to protect the health, welfare, and safety of long-term care consumers, the proposed rules shall apply to all certificate of need applicants for assisted living residences and comprehensive personal care homes, regardless of their size.

Recordkeeping, reporting, and other compliance requirements in the proposed amendments include the filing of a certificate of need application, which provides a description of the proposed facility and program of services and copies of the resident service contract and two-way transfer agreements with hospitals (see N.J.A.C. 8:33H-1.8 and 1.10). These requirements should not impose substantial additional costs on small businesses, because they are part of the customary business plan that a developer/operator would need to compile in any case. One other requirement in the proposed amendments entails recordkeeping and reporting with regard to client access to care: assisted living residences must submit documentation that at least 20 percent of their residents have nursing home-level care needs (see N.J.A.C. 8:33H-1.8(g), and comprehensive personal care homes must document that at least five percent of their residents are Supplemental Security Income recipients (see N.J.A.C. 8:33H-1.10(n)). These requirements are to be met on an annual basis; recordkeeping and reporting costs should be minimal because each facility will probably gather this information anyway as part of its billing process.

The cost of recordkeeping, reporting, and other compliance requirements in the proposed amendments are minimized for small and large businesses alike, in the fact that there will be a non-competitive, expedited Certificate of Need review process assisted living residences and comprehensive personal care homes. The expedited review process is generally less-time-consuming and costly than a full competitive review. For these reasons, the Department has determined that no differentiation based upon business size should be offered.

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

8:33H-1.1 Scope and purpose

(a) [The purpose of this chapter is to supplement N.J.A.C. 8:100-16, the Long-Term Care subchapter of the "State Health Plan," by setting forth Certificate of Need and related planning requirements which are necessary to effectuate N.J.A.C. 8:100-16.] **The purpose of this chapter is to set forth Certificate of Need and related planning requirements for long-term care services.**

(b) (No change.)

(c) The rules contained in this chapter address the Certificate of Need requirements for the following categories and types of facilities, as they are defined in N.J.A.C. 8:33H-1.2:

1. Nursing homes;

2. [Adult day health care programs] **Comprehensive personal care homes;**

3.-4. (No change.)

5. [Continuing care retirement communities;] **Assisted living residences;**

6.-7. (No change.)

[(d) N.J.A.C. 8:100-16 proposes the creation of new categories of care, referred to as alternate family care programs, assisted living residences, and comprehensive personal care homes. Until such time as licensing standards for such categories have been adopted, there shall be no Certificate of Need application process for these services.]

Recodify existing (e) through (h) as **(d) through (g)** (No change in text.)

8:33H-1.2 Definitions

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

["Adult day health care program" means a facility which is licensed by the Department of Health to provide preventive, diagnostic, therapeutic, and rehabilitative services under medical supervision to meet the needs of functionally impaired adult patients. Adult day health care facilities provide services to patients for a period of time which does not exceed 12 hours during any calendar day.]

**"Aging in place" means a process whereby individuals remain in their living environment despite the physical and/or mental decline and growing needs for supportive services that may occur in the course of aging. For aging in place to occur, services are added, increased, or adjusted to compensate for the person's physical and/or mental decline.**

**"AIDS Community Care Alternatives Program" or "ACCAP" means a Medicaid Federal waiver program which offers all Medicaid services plus special home and community-based services, including case management, to persons who are financially eligible and diagnosed as having AIDS. At a minimum, the person must meet the nursing facility level of care criteria and be maintained in the community at a cost that is no greater than the cost to Medicaid for institutional care.**

"Alternate family care" means a contractual arrangement **between a client, an alternate caregiving family, and a sponsoring agency** whereby no more than two individuals in need of long-term care receive room, board, and care in the private residence of a non-related family that has been trained to provide the necessary caregiving.

. . .

**"Assisted living" means a coordinated array of supportive personal and health services, available 24 hours per day, to residents who have been assessed to need these services, including residents who require formal long-term care. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.**

"Assisted living residence" means [an establishment that offers apartment-style housing, congregate dining, assistance with activities of daily living, and nursing care and supervision as needed to four or more adult persons unrelated to the proprietor. Apartment units offer at least one unfurnished room per resident, a private bath, and a lockable door on the unit entrance.] **a facility which is licensed by the Department of Health, in accordance with N.J.A.C. 8:36, to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, to four or more adult persons unrelated to the proprietor. Apartment units offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance.**

"Commissioner" means the State Commissioner of Health.

"Community Care Program for the Elderly and Disabled" or "CCPED" means a Medicaid-funded, Federally waivered program offering **all Medicaid services plus special home and community-based services, including** case [managed home and community-based care] **management** to persons who meet specific medical and financial nursing facility eligibility criteria. **At a minimum, the person must meet the nursing facility level of care criteria and be maintained in the community at a cost that is no greater than the cost to Medicaid for institutional care.**

"Comprehensive personal care home" means [an establishment that provides food, shelter, assistance with activities of daily living, and nursing care and supervision as needed to four or more adult persons unrelated to the proprietor.] **a facility which is licensed by the Department of Health, in accordance with N.J.A.C. 8:36, to provide room and board and to assure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance.**

"Continuing care retirement community" means the provision of lodging and nursing, medical, or other related services at the same or another location to an individual pursuant to an agreement effective for the life of the individual or for a period greater than one year, including mutually terminable contracts, and in consideration of the payment of an entrance fee with or without other periodic charges. A fee which is less than the sum of the regular periodic charges for one year of residency is not considered an entrance fee. **For Certificate of Need exemption purposes, a new or proposed community which will have fewer than four independent living units per nursing facility bed, or an existing community which proposes to construct additional nursing facility beds which will be utilized by persons who have not paid the entrance fee, is not a continuing care retirement community.**

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"Deficiency" means a finding or findings by the Department of Health that a facility is not in compliance with applicable State licensure requirements and/or Federal requirements for a health care facility. A deficiency remains valid unless overruled [in an Office of Administrative Law hearing] **by the Commissioner of Health** or a judicial appeal process.

. . .

**"Nursing home-level care" means care provided to individuals who have chronic medical condition(s) resulting in moderate to severe impairments in physical, behavioral, cognitive, and/or psychosocial functioning. The need for nursing home-level care and services is determined by a registered nurse and identified in a plan of care, in accordance with N.J.A.C. 8:36-7.1 "Nursing home-level care" includes, but is not limited to, partial or total assistance with activities of daily living (for example, bathing, dressing, eating, toileting, mobility), assistance with self-administering or administration of medications, and provision of treatments and periodic reassessments as directed by the plan of care. It may also include the provision of physiotherapy, occupational therapy, therapeutic counseling, and other rehabilitative services as indicated by the individual's medical condition.**

. . .

"Statewide restricted admissions facility" means a non-profit nursing home owned and operated by a [religious or] fraternal organization that serves only members of that organization and their immediate families.

AGENCY NOTE: N.J.A.C. 8:33H-1.3 is recodified as N.J.A.C. 8:33H-1.20.

[8:33H-1.3]**8:33H-1.20** Relationship between licensure and certificate of need requirements

(a) The provisions of [N.J.A.C. 8:100-18,] N.J.A.C. 8:39, **Licensing Standards for Long-Term Care Facilities**, N.J.A.C. 8:43, **Manual of Standards for Licensure of Residential Health Care Facilities,** and [N.J.A.C. 8:43F, Standards for Licensure of Adult Day Health Care Facilities,] **N.J.A.C. 8:36, Standards for Licensure of Assisted Living Residences and Comprehensive Personal Care Homes,** are hereby incorporated by reference. Applicants receiving certificate of need approval under the provisions of this chapter shall comply with all applicable licensing requirements of N.J.A.C. 8:39, [N.J.A.C. 8:43F,] **N.J.A.C. 8:36,** and N.J.A.C. 8:43.

**8:33H-1.3 "Window of opportunity" approach to planning long-term care alternatives**

**(a) Notwithstanding other provisions of this chapter, and in the interest of stimulating the development of new long-term care alternatives, the Department of Health hereby effectuates an 18-month "window of opportunity," during which applicants for assisted living residences and comprehensive personal care homes may file a Certificate of Need application which shall receive an expedited review. Applications submitted during this time shall be reviewed in accordance with the pertinent requirements set forth in this chapter, but shall not be subject to a need methodology.**

**1. The "window of opportunity" shall commence on the date these rules become effective; that is, the date the adopted rules are published in the New Jersey Register.**

**2. Prior to the conclusion of the 18 month "window of opportunity" on (insert date upon adoption), the Department shall propose a new need methodology for all long-term care services and new criteria for a full competitive Certificate of Need review process for assisted living residences and comprehensive personal care homes. Effective at the conclusion of the "window of opportunity," the expedited review process for these facilities will no longer be available.**

**3. At such time as the Department of Health adopts licensing standards for alternate family care programs, as defined at N.J.A.C. 8:33H-1.2, the Department shall also adopt amendments to this chapter to effectuate a "window of opportunity," during which applicants for alternate family care programs may file a Certificate of Need application which shall receive an expedited review.**

8:33H-1.4 Role of counties, Local Advisory Boards, and the State in long-term, care planning

(a) (No change.)

(b) In each county where there is a projected need for new long-term care placements in accordance with the methodology specified in N.J.A.C. 8:33H-1.5, the Long-Term Care Committee shall formulate a proposal specifying the mix of options and the number of placements of each type that are to be developed in the county. Options shall be:

1.-2. (No change.)

[3. Adult day health care;]

[4.]**3.** [Upgraded residential health care facilities, otherwise to be known as comprehensive] **Comprehensive** personal care homes;

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

(c) (No change.)

(d) The Local Advisory Board shall make a determination as to whether each county's placement mix proposal and the process whereby it was developed by the county Long-Term Care Committee comply with all applicable requirements contained in this chapter [and in N.J.A.C. 8:100-18].

1.-2. (No change.)

3. In the event that a county has not developed a placement mix proposal which is accepted by the Local Advisory Board within the time frame stipulated in (c) above, a "default" proposal shall be developed and implemented for the county by the State Health Planning Board. Options available in the default mix proposal shall be:

i.-ii. (No change.)

[iii. Adult day health care slots; and]

Recodify iv-v as **iii-iv** (No change in text.)

(e)-(m) (No change.)

8:33-1.5 Projection of need for long-term care placements

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

(d) The formula for computing the number of long-term care placements needed shall be as follows:

1. (No change.)

2. From each county's total computed in (d)1 above, subtract the county's current inventory of long-term care placements, which shall include the following:

i. (No change.)

ii. Home and community-based service waiver slots, including those currently available to the county and those which have been requested in the county's placement mix proposal, [(]accepted in accordance with N.J.A.C. 8:33H-1.4-(c)1[)];

iii. (No change.)

iv. Alternate family care placements, including those currently in use and those which have been requested in the county's placement mix proposal, [(]accepted in accordance with 8:33H-1.4[)];

v. **Licensed and Certificate of Need-approved** [Assisted] **assisted** living residence units [which have been requested in the county's placement mix proposal (accepted in accordance with N.J.A.C. 8:33H-1.4)]; and

vi. **Licensed and Certificate of Need-approved** [Comprehensive] **comprehensive** personal care beds [which have been requested in the county's placement mix proposal (accepted in accordance with N.J.A.C. 8:33H-1.4)].

3. (No change.)

(e) (No change.)

8:33H-1.6 Pediatric long-term care

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

[(d) Until such time as specific licensing standards and Certificate of Need requirements for pediatric day health care programs are adopted by the Department, applicants proposing these programs to serve chronically ill, medically fragile children, shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. Subsequent to Certificate of Need approval, the applicant shall apply to the Department for a waiver to the adult day health care licensing requirements contained in N.J.A.C. 8:43F which are not appropriate or applicable to the treatment of children.

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1. The applicant shall identify the licensing requirements contained in N.J.A.C. 8:43F for which a waiver will be necessary.

2. The applicant shall describe in detail the proposed program, target patient population, admission and discharge criteria, and the services to be provided.]

[8:33H-1.8 Adult day health care programs

(a) Applications for new adult day health care programs and additions to existing programs shall only be approved in counties where there is a long-term care placement need in accordance with N.J.A.C. 8:33H-1.5 and where adult day health care slots are requested as part of the county's long-term care placement mix proposal, as described in N.J.A.C. 8:33H-1.4.

(b) An applicant proposing to eliminate or reduce the capacity of an existing adult day health care program shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33, and shall comply with N.J.A.C. 8:33H-1.13(h).

(c) Priority shall be given to the approval of adult day health care programs that propose to serve a specified number of patients who are severely compromised in their ability to perform most or all activities of daily living. The applicant shall state the number of slots which, as a condition of Certificate of Need approval, will be dedicated for the care of patients who have these characteristics, identify potential referral sources, and describe how the program will be staffed to meet these patients' needs.

(d) Priority shall be given to the approval of programs to serve a specialized population, such as patients with Alzheimer's Disease and other behavior disorders or AIDS/HIV infection, provided that the applicant documents the need for the program among the identified patient population.

(e) As a condition of certificate of need approval, applicants shall have at least 20 percent of the approved slots utilized by Medicaid-eligible patients. This percentage, or a higher percentage if proposed by the applicant, shall be achieved within one year of licensure and maintained thereafter.

(f) Applicants proposing pediatric day health care programs shall comply with the requirements stated in N.J.A.C. 8:33H-1.6(d).]

**8:33H-1.8 Assisted living residences**

**(a) The applicant for an assisted living residence or for an addition to an existing, licensed assisted living residence shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33.**

**(b) The applicant shall provide a description of his or her professional track record, as it pertains to the ability to implement and operate high quality assisted living residences. The description shall include, but not be limited to, the applicant's experience serving an elderly/disabled population, history of compliance with applicable regulatory requirements, fiscal viability, and record of timely, successful implementation and management of previous projects.**

**1. Applicants who own, operate, or manage any licensed health care facilities in New Jersey or other states shall have their track record evaluated in accordance with the requirements in N.J.A.C. 8:33H-1.14.**

**2. To minimize the problem of "paper beds" (that is, approved but unimplemented facilities) and to facilitate the establishment of high quality assisted living providers, and notwithstanding the provisions of N.J.A.C. 8:33H-1.12(f), no more than three Certificate of Need approvals for unimplemented assisted living residences may be held by any applicant at any point in time.**

**(c) The applicant shall provide a description of the proposed assisted living services and a plan for how these services will be provided in the facility, in accordance with the licensing requirements at N.J.A.C. 8:36. The plan shall include, but not be limited to, a description of staff roles and responsibilities, staff orientation and training regarding assisted living concepts, and resident orientation and education regarding available services.**

**(d) The applicant shall provide a description of the proposed physical plant, including the square footage for each common area and square footage per residential unit. The applicant shall specify how the architectural design will promote the essential elements of assisted living, including privacy, active independence, autonomy, and a homelike environment. Furthermore, the applicant shall indicate how the physical plant will facilitate the care of residents with common long-term care problems such as reduced mobility, incontinence, and dementia.**

**1. An existing building or health care facility may be considered for approval as an assisted living residence, provided that the proposed structure is or will be in substantial compliance, as determined by the Department of Health, with all applicable physical plant requirements contained in N.J.A.C. 8:36.**

**(e) The applicant shall provide a description of the community in which the proposed assisted living residence will be located and a demographic analysis of the facility's target population. The applicant shall provide supporting documentation to show that the facility will be affordable given the socio-economic status of the target population, and that financially viable occupancy rates can be achieved given the size of the proposed facility in relation to the size and demographic characteristics of the target population.**

**(f) The applicant shall submit a draft copy of the resident service contract, indicating proposed charges for room and board and all levels of care and for all additional services not included in the standard package rates. This contract shall specify how and when the resident will be notified of any change in charges.**

**(g) The application shall include a statement of the applicant's commitment to assuring access to assisted living for individuals with nursing home-level care needs, as defined in N.J.A.C. 8:33H-1.2. Within 36 months after licensure, at least 20 percent of the facility's residents shall be individuals with nursing home-level care needs. This percentage shall be computed based on the number of resident days per calendar year and may include direct admissions as well as maintained residents with nursing home-level care needs. The facility shall report this information to the Department of Health by April 15 of each year for the prior calendar year.**

**(h) In order to assure two-way access to care between hospitals and the assisted living residence, the applicant shall maintain signed referral and/or transfer agreements with at least two New Jersey hospitals, including at least one State, county, or private psychiatric hospital. At the time of initial licensure, the facility shall sign and subsequently maintain these written agreements.**

**(i) Certificate of Need applications submitted subsequent to the time that Medicaid reimbursement for assisted living residences becomes generally available shall include a statement of commitment to provide access and continuity of care for Medicaid-eligible patients, including former psychiatric patients, who need nursing home level care.**

[8:33H-1.10 Continuing care retirement communities

(a) An applicant for a new or expanded continuing care retirement community shall submit an application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33.

(b) Continuing care retirement communities shall contain a minimum of four independent living units for every one long-term care bed.

1. Residential health care beds may be counted as independent living units in meeting the four-to-one ratio requirement in (b) above.

(c) The certificate of need application for a continuing care retirement community shall include the results of a detailed marketing study, analyzing demographic and economic conditions in the proposed service area, specifying and quantifying the target income-age group to which the continuing care retirement community will be marketed, identifying competing alternatives to the continuing care retirement community which are available to consumers in the service area, and estimating the number of potential continuing care retirement community residents residing in the proposed service area.

1. The applicant shall identify those municipalities that will constitute the target service area to which the continuing care retirement community will be marketed.

(d) The certificate of need application for a continuing care retirement community shall include a copy of the proposed resident

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contract or agreement. This contract shall clearly disclose the health care and other services to be provided by the community; the term or duration of the contract; projected charges, including entrance fees and periodic or monthly payments; and residents' rights. The contract shall fully disclose the circumstances under which the contract may be terminated both by the resident and the community and shall include provisions for the appeal rights of residents.

1. As a condition of certificate of approval, the resident contract shall specify that residents will have continued access to and use of the continuing care retirement community's long-term care beds in the event that they become Medicaid eligible, provided that the resident complies with all other terms of the contract and provided that this arrangement does not threaten the financial viability of the continuing care community as a whole.

(e) The long-term care facility of a continuing care retirement community shall be constructed concurrently with or subsequent to that number of independent living units which is stated in the Certificate of Need application. Licensure of the long-term care beds shall not be granted until such time as the proposed number of independent living units has been completed.

(f) Prior to licensure of the long-term care beds, the applicant shall obtain a certificate of authority from the Department of Community Affairs for the operation of a continuing care retirement community.

(g) Within seven years of occupancy of the first independent living unit, at least 90 percent of the occupants of the long-term care facility shall be drawn exclusively from the membership of the continuing care retirement community.

1. During the first seven years of operation, the continuing care retirment community may admit non-member patients from the outside community to the nursing home beds, however, in the beds occupied by non-members, the facility shall comply with the Medicaid utilization requirements specified in N.J.A.C. 8:33H-1.15.

(h) After seven years of occupancy of the first independent living unit, no more than 10 percent of the occupants of the long-term care facility may be drawn from outside the continuing care retirement community, and of this group, at least 45 percent must be Medicaid-eligible persons.

1. An exception to (h) above may be made for nursing homes in continuing care retirement communities where four or fewer beds are utilized by non-member patients on an annual basis. Such facilities may cease to meet the 45 percent Medicaid utilization requirement, provided that no Medicaid-eligible patient will be displaced from the facility as a result of this provision.

(i) An exception to the four-to-one ratio requirement stated in (b) above may be made in the case of continuing care retirement communities which have operated as such for at least five years and which propose to add nursing home beds exclusively to accommodate the needs of their continuing care retirement community members and their current patients. In this case, the applicant may be approved for a bed addition, provided that the applicant agrees to accept a condition of approval stipulating that the nursing home shall cease to admit any patients from outside the continuing care retirement community. From the time of certificate of need approval for the bed addition, the nursing home shall exclusively admit patients who are members of the continuing care retirement community.]

**8:33H-1.10 Comprehensive personal care homes**

**(a) In order to improve the utilization of readily available residential health care and "Class C" boarding home beds, to give current residents of these facilities the opportunity to age in place, and to improve access to care for many hospitalized patients and others who need long-term care placements, the Department shall give consideration to the conversion of residential health care facilities and "Class C" boarding homes to comprehensive personal care homes. The Department aims to preserve and promote the residential atmosphere of these settings, while enhancing the level of care and services they may provide, in accordance with the licensure standards at N.J.A.C. 8:36.**

**(b) The applicant for a comprehensive personal care home shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33.**

**(c) Eligibility for conversion to a comprehensive personal care home shall be open exclusively to the following:**

**1. Freestanding residential health care facilities which were either licensed or Certificate of Need-approved on or before the date that these rules become effective;**

**2. Residential health care beds located within a long-term care facility that was licensed or Certificate of Need-approved on or before the date that these rules become effective;**

**3. Licensed long-term care beds; and**

**4. "Class C" boarding homes which were licensed on or before the date that these rules become effective.**

**(d) Eligibility for the construction of new comprehensive personal care beds shall be open exclusively to the following:**

**1. Existing comprehensive personal care homes and existing facilities proposing conversion to a comprehensive personal care home that wish to add a limited number of beds. Within any five year period commencing at the time of licensure, the new construction of no more than 20 beds as an addition to an existing or proposed comprehensive personal care home may be considered for Certificate of Need approval.**

**i. Applicants who wish to add more than 20 beds shall apply for approval as an assisted living residence.**

**2. Hospice programs which have been Medicare-certified for at least 12 consecutive months. If approved, the facility shall be constructed using the current New Jersey Uniform Construction Code, Use Group I-1, which is applicable for residential health care facilities.**

**i. As a condition of Certificate of Need approval, the facility shall be occupied exclusively by patients who are eligible for hospice services.**

**ii. The facility shall contain no more than 20 comprehensive personal care beds at project completion.**

**(e) Only applications proposing the conversion of facilities which are capable of meeting the physical plant standards for licensure as a comprehensive personal care home, in accordance with N.J.A.C. 8:36, shall receive consideration for approval to convert to comprehensive personal care.**

**(f) Only applications proposing either conversion of the facility's entire complement of beds, or conversion of one or more separate and distinct units, wings, floors, or areas within the facility, shall receive consideration for approval to convert to comprehensive personal care.**

**(g) With regard to the facility's physical plant (for example, corridor widths, room size, handicap accessibility), the applicant shall identify the facility's capacity and limitations for meeting the needs of those residents who may require nursing home-level care. In this context, the applicant shall identify how and whether residents with common long-term care problems such as reduced mobility, incontinence, and dementia can safely and effectively be accommodated in accordance with the licensing standards at N.J.A.C. 8:36.**

**1. Comprehensive personal care homes shall have no more than two residents per bedroom. Applicants shall propose the conversion of that number of beds which will result in no more than two residents per room. If the facility has bedrooms with more than two occupants, the applicant shall propose a plan to achieve occupancy of no more than two residents per room in the comprehensive personal care beds.**

**(h) Applicants proposing the conversion of an existing, licensed residential health care facility or "Class C" boarding home shall provide a description of the facility, its current services, staff qualifications, the community in which it is located, linkages with other community agencies, residents' demographics (for example, age, race/ethnicity, payer mix), and recent occupancy data.**

**(i) The applicant shall provide a description of the proposed comprehensive personal care program and a plan for how it will be implemented in the facility, in accordance with the licensing requirements at N.J.A.C. 8:36. The plan shall include, but not be limited to, a description of new staff roles and responsibilities, staff orientation and training regarding assisted living concepts, resident orientation and education regarding new services to be provided,**

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**as needed, and specific changes in the operation of the facility which will be necessary to comply with the licensure standards for comprehensive personal care homes.**

**(j) Applicants who own, operate, or manage any licensed health care facilities in New Jersey or other states shall have their track record evaluated in accordance with the requirements in N.J.A.C. 8:33H-1.14.**

**(k) The applicant shall submit a draft copy of the resident service contract, indicating proposed charges for room and board and all levels of care and all additional services not included in the standard package rates. This contract shall specify how and when the resident will be notified of any change in charges.**

**(l) In order to assure two-way access to care between hospitals and the comprehensive personal care home, the applicant shall submit copies of signed referral and/or transfer agreements with at least two New Jersey hospitals, including at least one State, county, or private psychiatric hospital.**

**(m) Certificate of Need applications submitted subsequent to the time that Medicaid reimbursement for comprehensive personal care homes becomes generally available shall include a statement of commitment to provide access and continuity of care for Medicaid-eligible patients, including former psychiatric patients, who need nursing home level care.**

**(n) In converting to a comprehensive care home from a residential health care facility or Class C boarding home, the facility shall maintain its existing residents who are Supplemental Security Income-eligible recipients and former psychiatric patients. On an ongoing, annual basis, at least five percent of the facility's residents shall be Supplemental Security Income-eligible recipients, at least half of whom shall be former psychiatric patients. This percentage shall be computed based on the number of resident days per calendar year. The facility shall report this information to the Department of Health by April 15 of each year for the prior calendar year.**

**1. In the event that the facility's Supplemental Security Income-eligible residents develop the need for nursing home level care, as defined at N.J.A.C. 8:33H-1.2 and determined by Medicaid's preadmission screening process at N.J.A.C. 10:63, the facility shall maintain these residents in accordance with the licensing standards at N.J.A.C. 8:36, subject to the facility's discharge criteria in accordance with N.J.A.C. 8:36-4.1(d), provided that Medicaid reimbursement is available. However, if Medicaid reimbursement is not available, the facility shall make all necessary arrangements to transfer the person to a nursing home.**

8:33H-1.12 Residential health care facilities

(a) An applicant proposing a new [or expanded] residential health care facility shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. The applicant shall comply with the applicable utilization requirements for Supplemental Security Income recipients and former psychiatric patients, in accordance with 8:33H-1.15.

[(b) An applicant proposing the elimination or reduction of residential health care beds or the closure of a residential health care facility shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. The applicant shall comply with all applicable requirements pertaining to the conversion or elimination of beds, in accordance with N.J.A.C. 8:33H-1.13.]

8:33H-1.13 Conversion or elimination of licensed or Certificate of Need approved beds or services

(a) Applicants proposing to convert any licensed beds [to long-term care beds] shall submit schematic plans with a floor layout of the facility, illustrating how the proposed conversion will be accomplished. In order to assure that the bed conversion can be implemented in accordance with health facility construction standards, it is recommended that applicants consult with the Department's Office of Health Facilities Construction Services in the Division of Health Facilities Evaluation, prior to submitting a certificate of need application. Applications for bed conversions that are submitted without schematic plans shall be deemed incomplete.

(b) Applicants for the conversion of residential health care beds to long-term care beds [or the elimination of residential health care beds] shall document a commitment to enabling current residents to continue occupying their assigned beds until or unless a permanent relocation placement is requested by the resident.

1. (No change.)

(c)-(e) (No change.)

(f) Certificate of Need applications proposing the conversion of residential health care beds to long-term care beds [or the elimination of one or more residential health care beds] shall meet the following requirements:

1.-3. (No change.)

(g) (No change.)

[(h) Certificate of need applications proposing the elimination or termination of an adult day health care program may be approved, provided that the following condition is met:

1. The applicant shall provide documentation of a transfer agreement with at least one other licensed adult day health care program in the county that maintains admission policies, offers services, and charges fees which are similar to those of the applicant's program. Furthermore, if the applicant currently has patients utilizing the adult health care program, the applicant shall provide documentation that the program which is to be the subject of the transfer agreement has the willingness and slot capacity to accommodate those patients who will be transferred from the applicant's program.]

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

8:33H-1.14 Quality of care and licensure track record requirements for long-term care, **assisted living residences, comprehensive personal care homes, and** residential health care[, and adult day health care] facilities

(a) (No change.)

(b) Applicants shall demonstrate the capacity to provide a quality of care which meets or surpasses the requirements contained in the applicable licensing standards for the facility. Evidence of the capacity to provide high quality care shall include (b)1 below and may also include (b)2 through 4 below:

1. A satisfactory record of compliance with licensure standards in existing health care facilities which are owned, operated, or managed, in whole or in part, by the applicant. This [may] **shall** include reports issued by licensing agencies from other states, as well as from the Department;

2.-4. (No change.)

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

(e) In evaluating track record [in (c) or (d) above], the Department may consider any evidence of noncompliance with applicable licensure **and certification** requirements provided by an official state licensing **and/or certification** agency in any state outside of New Jersey, or any official records from any agency of the State of New Jersey indicating the applicant's non-compliance with the agency's licensure or certification requirements in a facility the applicant owned, operated, or managed in whole or in part.

**1. It is the responsibility of the applicant to contact all relevant licensing and certification agencies in all other states where the applicant owns, operates, or manages facilities, in order to secure letters or other documentation from them attesting to the track record of the applicant in those states. This documentation shall be submitted by the applicant as part of the Certificate of Need application.**

(f)-(i) (No change.)

8:33H-1.18 Location of facilities

(a) The applicant shall describe the proposed site of a project and the immediate surrounding community, identifying how the site is currently zoned and providing a time table for securing any and all necessary zoning and land use approvals. [Long-term care] **The construction of new or replacement** facilities proposed to be located on sites which are currently zoned for heavy industrial use shall not be approved.

1. Applicants [for long-term care, residential health care, and adult day health care facilities] should not enter into costly land use

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or zoning approval procedures prior to receiving an approved Certificate of Need.

(b) (No change.)

(c) The applicant for a [long-term care or residential health care] **new** facility shall describe the availability to the proposed site of all necessary utilities. Where utilities are not already available at the proposed site, the applicant shall provide a timetable and detail the costs for obtaining these utilities.

(d) The applicant shall identify the proposed facility's proximity to any potential source of adverse environmental conditions. [Long-term care and residential health care facilities] **Facilities** shall be located so as to prevent exposure of [patients] **residents** to adverse environmental conditions which might hamper or interfere with their care, including excessive noise levels, offensive odors, or unsightly physical surroundings.

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# (a)

## DIVISION OF HEALTH FACILITIES EVALUATION

## Standards for Licensing Nursing Home Administrators

## Proposed Repeal and New Rule: N.J.A.C. 8:34

Authorized By: Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with approval of the Nursing Home Administrator Licensing Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5b, 26:2H-27 and 26:2H-28.

Proposal Number: PRN 1993-444.

Submit comments by September 15, 1993 to:
Ms. Wanda Marra
Acting Executive Director
Nursing Home Administrator Licensing Board
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625-0367

The agency proposal follows:

**Summary**

Pursuant to Executive Order No. 66(1978), N.J.A.C. 8:34 will expire on November 15, 1993. The Licensing, Certification, and Standards Program has reviewed the rule and determined that the rules are necessary in order to implement the program of licensure of nursing home administrators. However, the rules currently at N.J.A.C. 8:34 do not conform to current standards of practice. Therefore, the Program, with the approval of the Nursing Home Administrators Licensing Board (Board) is proposing to repeal the current text of the rules and replace it with a proposed new chapter of Standards for Licensing Nursing Home Administrators.

The Nursing Home Administrators Licensing Board was initially established as a result of the 1967 amendments to the Social Security Act. These Federal amendments, found at 42 CFR 431.700 et seq., stipulated that a State Plan for medical assistance under Title XIX of the Social Security Act must include a program for the licensure of administrators of nursing homes administered by a Nursing Home Administrators Licensing Board.

N.J.S.A. 26:2H-5(b) was adopted in 1971, serving as the enabling act under New Jersey law for the establishment of the Board. In addition, the requirements and qualifications of nursing home administrators are also incorporated into OBRA '87, the Nursing Home Reform Act, 42 CFR 483B, and the Health Care Financing Act's implementing regulations.

With the exception of recent amendments to the subchapter concerning license and examination fees (see 24 N.J.R. 3161, proposed July 6, 1992 at 24 N.J.R. 2414(a) and adopted August 12, 1992, effective September 8, 1992), the rules which comprise this current chapter have been in effect, with minimal change, since November, 1972. These amendments increased the examination fee for nursing home administrators from $100 to the current cost of the examination, as determined by the National Association of Boards.

The substantive provisions of the respective subchapters follows, with emphasis on those changes that are being made with these proposed new rules.

N.J.A.C. 8:34-1, General provisions, provides for the source of authority which establishes the Nursing Home Administrators Board, the scope of the rules, the scope of practice for licensed administrators, and the purpose of the rules. Also contained in the subchapter are definitions of the words and terms used throughout the chapter, an explanation of the severability of the rules, and the Nursing Home Administrators Board's authority to waive provisions of this chapter.

N.J.A.C. 8:34-2, describes the general powers of the Board, including the authority to delegate certain functions of the Board to a designee. Newly addressed provisions of this subchapter include a definition of a quorum for the purposes of conducting Board business, record keeping requirements, and the capability to recommend the assessment of civil penalties in a disciplinary action against an administrator to the Commissioner of Health.

N.J.A.C. 8:34-3, Licensure requirements, describes the application and licensure procedure for individuals desiring to become administrators. The applicant must complete a series of forms, including an application form, approval of internship training program form and quarterly report forms. In addition, the applicant must submit three references, verification of completion of 10 hours of health related courses and seminars and proof of completion of at least a bachelor's level degree.

N.J.A.C. 8:34-4, Administrative experience requirement, describes the administrative experience requirement and the administrator-in-training program and sets forth the requirements for written plans and reports to be completed as part of the administrator-in-training program. Additionally, the Board is now requiring that Board-approved preceptors supervise the administrator-in-training. Subchapter 4 contains the requirements the preceptor must comply with in order to be approved to serve as a preceptor.

N.J.A.C. 8:34-5, Scope of administrator's responsibility, sets forth the administrator's responsibilities in assuring the facility is operating in compliance with N.J.A.C. 8:39, Licensing Standards for Long Term Care Facilities.

N.J.A.C. 8:34-6, Examination, identifies the examination necessary for license, the examination fee, examination grading, and examination schedule. This subchapter also addresses avenues of recourse for individuals deemed ineligible to sit for the license examination.

N.J.A.C. 8:34-7, Licensure, addresses a number of licensing issues. These include the guidelines for the issuance of an initial and duplicate license; renewal of a license; displaying a license; the use of the title "Licensed Nursing Home Administrator"; the reporting to the Board of changes in an administrator's name, address, or employment; the granting of a license by equivalency; and the inactive status of a license.

N.J.A.C. 8:34-8, Continuing education, describes the continuing education requirement, waiving of this requirement or extending a waiver of the requirement, and the Nursing Home Administrators Licensing Board's administrative and record keeping responsibilities regarding continuing education credits.

N.J.A.C. 8:34-9, Suspension, revocation, and hearings, sets forth the rules for the suspension, revocation, or denial of a license, the hearing rights which must be afforded to a licensee and the conditions for restoration and reinstatement of a license. N.J.A.C. 8:34-9(c) provides for a right of inquiry by the Board into the operation of the facility and the review of the statement of deficiencies and penalties issued by the Department against a facility.

N.J.A.C. 8:34-10, Fees, establishes a fee schedule, to be instituted by the Board.

**Social Impact**

In proposing these rules, the Nursing Home Administrators Board is complying with its statutory mandate to provide for the development, establishment and enforcement of basic standards for the training, experience, education and discipline of individuals acting as nursing home administrators. The proposed rules will provide regulatory authority over individuals licensed as nursing home administrators and provide rules to direct the Board in fulfilling its regulatory responsibilities.

State regulation of nursing home administrators helps to ensure the continuing availability of appropriately trained administrators to direct the delivery of quality physical, emotional and social care to the residents of New Jersey nursing homes.

As noted in the Summary, the Federal government requires each state to have a licensure program. Failure to maintain such a program will

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result in the loss of millions of dollars of Federal Medicaid funds to the State, which will severely impact the delivery of a wide spectrum of services to our aging population residing in nursing homes, drastically affecting the quality of their lives. On July 1, 1993, the Boards issued license renewals to 1,113 New Jersey licensed administrators. There are approximately 340 licensed nursing homes in this State, providing care for over 55,000 residents.

**Economic Impact**

The proposed rules will have an economic impact on the approximately 1,050 administrators licensed in New Jersey. The biennial license renewal fee is being increased from $100.00 to $150.00. In addition, a fee of $25.00 will be required for the late renewal of a license, $10.00 will be required for the issuance of a duplicate license or certificate, and $175.00 for the restoration of a license. Beginning with the adoption of these rules, the Department will charge an annual fee of $25.00 to the organization or individual requesting Board approval of their sponsorship of a continuing education program. The cost to administrators attending continuing education programs may increase if the individuals or groups providing these programs raise the program fees and pass this increase on to the attendees.

Applicants for licensure will also be required to pay a licensure fee, in addition to an original application fee. Those individuals taking the licensing examination will be required to pay a fee, which is currently $175.00, but which may vary with the cost of the examination to the Board by the testing agency, in accordance with N.J.S.A. 30:11-13.

The newly adopted fee schedule will increase the revenues generated and decrease the monies required from the New Jersey Department of Health to fund the operation of the Nursing Home Administrator Board. No economic impact upon the residents of nursing homes or the consumer in general is expected.

**Regulatory Flexibility Statement**

The proposed repeal and new rules have been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The provisions impose no reporting, recordkeeping or other compliance requirements on small businesses; therefore a regulatory flexibility analysis is not required. The new rule impacts only on licensed Nursing Home Administrators to the extent that they must submit documentation of compliance with the continuing education requirement with their license renewal form. Prospective administrators must submit an application for licensure and documentation of compliance with the requirements for licensure. Preceptors must complete quarterly reports relating the performance of those individuals in the administrator-in-training program.

**Full text** of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 8:34.

**Full text** of the proposed new rules follows:

CHAPTER 34
RULES FOR LICENSING NURSING HOME ADMINISTRATORS AND RULES REGULATING THE NURSING HOME ADMINISTRATOR BOARD

SUBCHAPTER 1. GENERAL PROVISIONS

8:34-1.1 Source of Authority

These rules shall be known as the "Rules for Licensing Nursing Home Administrators" adopted by the New Jersey State Department of Health and promulgated pursuant to the authority of N.J.S.A. 26:2H-27 and 26:2H-28 and N.J.S.A. 30:11 et seq.

8:34-1.2 Scope of rules

(a) This chapter contains rules for licensing nursing home administrators in New Jersey and rules regulating the Nursing Home Administrators Licensing Board.

(b) The rules of the Department shall be supplemental to the laws providing for the licensing of nursing home administrators and shall have the force and effect of law.

(c) The rules of the Board are intended to be consistent with the applicable Federal and State law and shall be construed whenever necessary, to achieve such consistency.

8:34-1.3 Scope of individual practice

(a) This chapter shall apply to all individuals who seek to secure a New Jersey license as a nursing home administrator; all individuals who currently are licensed; and all individuals who are in inactive status.

(b) The scope of practice for a licensed nursing home administrator is defined as the provision of physical and emotional health services for persons who require various therapeutic and protective measures in a supervised environment.

(c) The licensed nursing home administrator performs functions including, but not limited to, ensuring quality resident care management, personnel management, financial management, environmental management, regulatory management, organizational management, marketing, and community and public relations.

8:34-1.4 Scope of administrator responsibility

(a) The licensed administrator shall be responsible for the administrative functions at the facility to assure that the facility is operated at all times in compliance with N.J.A.C. 8:39, Licensing Standards for Long Term Care Facilities.

(b) In a facility where a licensed administrator has both administrative and other functions, the facility shall maintain time schedules which delineate clearly the specific hours spent by the administrator in each function.

8:34-1.5 Purpose

The purpose of this chapter is to implement the provisions of P.L. 1968, c.356 and by so doing, provide for the requirement of the education, experience, continuing education, and disciplinary processes of individuals acting as administrators of long term care facilities, in order to ensure safe and adequate treatment of all individuals in long term care facilities, and for the operation of the Nursing Home Administrator Board.

8:34-1.6 General Definitions

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

"Assistant administrator" means an individual employed in a licensed nursing home who assists the nursing home administrator in performing the prescribed functions of that position, has administrative responsibility for all areas of the facility and direct line responsibility to the administrator, and who may be designated to serve as administrator in the absence of the administrator.

"Administrator-in-training" (AIT) means an individual who is participating in a Board approved training program to become a licensed nursing home administrator.

"Board" means the Nursing Home Administrator Licensing Board (NHALB) of the New Jersey State Department of Health.

"Commissioner" means the Commissioner of the New Jersey State Department of Health.

"Department" means the New Jersey State Department of Health.

"Full-time" means at least 35 hours of work per week.

"Institution of higher learning" means an institution accredited by the New Jersey Department of Higher Education or its out-of-State equivalent.

"License" means a certificate issued by the Department upon recommendation from the Nursing Home Administrator Board which indicates that the bearer has been licensed by that body as meeting the standards contained in this chapter.

"Nursing home" means a nursing facility licensed pursuant to the Health Care Facilities Planning Act, P.L. 1971, c.136 and 138, N.J.S.A. 26:2H-1 et seq., and amendments thereto, or an out-of-State nursing facility licensed pursuant to similar licensure regulations.

"Nursing home administrator" means an individual who holds a valid New Jersey nursing home license, whether or not such individual has an ownership interest in such home and whether or not such functions and duties are shared with one or more other individuals.

"Preceptor" means an individual who holds a valid nursing home administrator license and who has been approved by the Board in accordance with N.J.A.C. 8:34-4.3 to be responsible for the training of an AIT.

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8:34-1.7 Severability

In the event that any provision of these rules is declared unconstitutional or invalid, or the application thereof to any person or circumstance is held invalid, the applicability of such provision to other persons and circumstances and the constitutionality or validity of every other provision of these rules shall not be affected thereby.

8:34-1.8 Waiver

(a) After due consideration, the Department, upon recommendation from the Board, may waive any provisions of this chapter for good cause, if such a waiver would not endanger the health, safety, or welfare of residents in a long term care facility.

(b) A facility seeking a waiver of the standards in this chapter shall apply in writing to the Executive Director of the Board.

(c) A written application for waiver shall include the following:

1. The nature of the waiver requested;
2. The specific standard for which a waiver is requested;
3. Reasons for requesting a waiver;
4. An alternative proposal which would ensure the health and safety of the residents; and
5. Documentation to support the waiver application.

## SUBCHAPTER 2. NURSING HOME ADMINISTRATORS LICENSING BOARD

8:34-2.1 General powers

(a) A majority of the currently serving membership of the Board shall constitute a quorum for the transaction of business at any meeting.

(b) The Board, or its designee, shall be responsible for determining the minimum eligibility requirements to take the nursing home administrator licensing examination.

(c) The Board may recommend to the Commissioner the assessment of a civil penalty, in accordance with N.J.S.A. 30:11-4(a), against a nursing home administrator for violation of, or failure to comply with, any order or rule issued or adopted by the Board, or any provision of this chapter.

(d) The Department shall maintain a registry of all licensed long term care administrators and a file of applicants for licensure.

## SUBCHAPTER 3. LICENSE REQUIREMENTS

8:34-3.1 Requirements for license

(a) An applicant for a license as a nursing home administrator shall:

1. Be at least 18 years of age;
2. Be a citizen of the United States or have declared the intent to become same;
3. Have, at a minimum, a baccalaureate degree from an institution of higher learning;
4. Have served as an assistant administrator or AIT in a licensed nursing home or a facility with licensed long term care beds for at least 1,750 hours at a rate of no more than 50 hours per week. This requirement may be completed on a part time basis. In no instance shall said administrative experience have been more than two years prior to the submission of the application for examination (see also N.J.A.C. 8:34-4.4);
5. Have successfully completed 100 seminar or course hours in areas relevant to long term care administration as determined by the Board;
6. Be of good moral character as required in N.J.S.A. 30:11-13; and
7. Have passed an examination approved by the Board for the licensing of nursing home administrators.

(b) A baccalaureate degree shall not be required for an individual to serve as an AIT or assistant administrator.

(c) A new applicant for licensure shall undergo a background check by the New Jersey State Police at the applicant's expense.

(d) Pursuant to N.J.S.A. 30:11-1.1, no license shall be issued to any person who has ever been convicted of a crime involving moral turpitude or to any person who has been found guilty of violating the provisions of this chapter by a court of competent jurisdiction.

8:34-3.2 Application procedure

(a) An applicant for a license as a nursing home administrator shall submit the following to the Board:

1. A completed application form;
2. Declaration of intent to become a citizen, if applicable;
3. A non-refundable licensure application fee as set forth in N.J.A.C. 8:34-9.1(a)1;
4. An official transcript from a college or university accredited by the State Department of Higher Education;
5. Three references attesting to the applicant's administrative ability and character from health care professionals who are not related to applicant, nor who have been, or currently are, a patient or client in a business relationship of the applicant. The current preceptor of the applicant may submit a reference on behalf of the applicant, but that reference shall be in addition to the required three references;
6. Documentation of administrative experience identified at N.J.A.C. 8:34-4.1(a);
7. Documentation of successful completion of 100 course hours identified at N.J.A.C. 8:34-3.1(a)5;
8. National examination scores from previous licensing examinations for administrators applying for license by equivalency, as identified at N.J.A.C. 8:34-3.1(a)7, if applicable;
9. Documentation of involvement on the part of the applicant in disciplinary proceedings with a licensure board or governmental agency in any jurisdiction the applicant is, or has been, licensed as an administrator, and where, as a result of that proceeding, a sanction of at least the level of a written warning was imposed on the administrator, if applicable;
10. Documentation of any conviction of a felony violation of state of Federal law; and
11. A notarized statement on the application by the applicant indicating that the statements and documents are true and correct.

(b) Effective January 1, 1994, an application submitted to the Department shall remain active for a period of two years, by the end of which applicant shall meet all requirements to be deemed eligible to take the licensing examination.

(c) An applicant may request an extension of the two year period. Documentation of progress towards meeting the license requirements shall be submitted by the applicant prior to the expiration of the initial two year period. An extension may be granted by the Board or its designee under conditions to be determined by the Board.

(d) At the expiration of the two year period, an application for licensure will be deemed inactive and an applicant may, at the discretion of the Board, be required to resubmit an application.

## SUBCHAPTER 4. ADMINISTRATIVE EXPERIENCE REQUIREMENT

8:34-4.1 Administrative experience requirement

(a) An applicant for licensure shall comply with the requirement of N.J.A.C. 8:34-3.1(a)4 through participation or employment in one of the following:

1. An administrator-in-training program that meets the requirements identified at N.J.A.C. 8:34-4.2(a) and is approved by the Board; or
2. An assistant administrator position, with the following conditions:

i. The applicant shall have the equivalent of one year full-time or two years part-time administrative experience, as an assistant administrator, totaling 1,750 hours in a nursing home, or licensed facility with long term care beds, within the five year period immediately prior to submission of an application; and

ii. The Board approves the job description for the specific position; in accordance with the requirements of this chapter; and

iii. The administrator submits documentation to the Board verifying the performance record of the assistant administrator until 1,750 hours of experience is completed.

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8:34-4.2 Administrator-in-training (AIT) program

(a) An AIT program shall be approved by the Board prior to the individual beginning. The program shall be:

1. Conducted in a nursing home or facility with licensed long term care beds licensed in accordance with N.J.A.C. 8:39. The facility shall be in compliance with the track record requirements of N.J.A.C. 8:33-4.10(e)2; and

2. Under the preceptorship of a nursing home administrator who has been approved by the Board in accordance with N.J.A.C. 8:34-4.3; and

3. For a period of 1,750 hours, or as required by the Board after evaluation of the applicant's education and experience based upon the requirements contained in this chapter; and

4. With a minimum of 875 hours, or half of the hours required by the Board, served while a licensed administrator is on the premises of the nursing home.

(b) An AIT program approved by the Board shall provide at least 70 hours of administrative experience in each of the following service areas:

1. Administration,
2. Business office,
3. Nursing,
4. Resident activities,
5. Social service,
6. Medical records,
7. Dietary,
8. Maintenance, and
9. Environmental, including housekeeping/laundry.

(c) The hours of administrative experience to be provided in addition to (b) above shall be submitted to the Board for approval in the form of a program plan and shall be completed in areas of the AIT's need, after consideration by the Board of the AIT's previous work experience, training and education.

(d) The Board may waive, in accordance with N.J.A.C. 8:34-1.8, and after review of an individual's application, some or all of the hours required to meet the administrative experience requirement set forth at N.J.A.C. 8:34-4.2(a). This may include a waiver of any of the hours set forth at N.J.A.C. 8:34-4.2(b)1-9.

(e) If the AIT is working in a nursing home in another capacity, the preceptor shall conspicuously post the schedule stating when the AIT is performing as an AIT and when the AIT is working in another capacity.

(f) If the AIT is a department head, a notice shall be conspicuously posted in the nursing home stating who the acting department head will be while the AIT is performing administrative duties. A copy of this notice shall be forwarded to the Executive Director of the Board.

(g) An AIT program of 1,750 hours shall be completed within two years, or if 875 hours or less is required by the Board, within one year.

8:34-4.3 Preceptor for administrator-in-training

(a) A preceptor shall be responsible for supervising an AIT and for scheduling hours and activities for an AIT.

(b) A preceptor shall have held a valid license as a nursing home administrator for at least five years and shall have practiced as a licensed nursing home administrator in a long term care facility for at least three years immediately preceding serving as a preceptor.

(c) A preceptor shall be employed full time in the nursing home where the training program occurs.

(d) The preceptor shall notify the Board, in writing, if an AIT leaves the program, there is a change of preceptor, or there is a change in an approved training plan.

(e) Any change in an approved training program shall be submitted to the Board in writing for reapproval.

(f) The Board may refuse to approve a preceptor for training AITs if:

1. There is good cause to believe that the preceptor has failed to provide proper training and supervision for AITs previously under preceptor's responsibility in an AIT program; or

2. The preceptor has been subject to a disciplinary action by the Board within 12 months immediately preceding the start of the AIT program.

(g) A licensed nursing home administrator shall not function as a preceptor for more than two AITs at any one time.

8:34-4.4 Equivalency of internship requirement

(a) The service requirement identified at N.J.A.C. 8:34-3.1(a)4 shall be deemed to have been met if the applicant:

1. Has been awarded a Master's degree in Health Care Administration or Public Health Administration, or their equivalent, by an accredited institution of higher learning; and

2. Has completed an internship program approved by the institution awarding the Master's degree, of not less than 450 hours, or as determined by the Board to be substantially equivalent, in a nursing home or a facility that provides licensed long-term care services and has completed said internship within five years immediately preceding application to the Board for licensure.

(b) An applicant who possesses a Master's degree, as identified in (a) above, and who has not completed an approved program through the Master's program, shall be required to complete not less than 875 hours, or six months full-time experience in a nursing home or licensed facility that provides long term care services as an AIT or assistant administrator.

8:34-4.5 Written plan and reports

(a) An AIT program approval form shall be completed and submitted to the Board or its designee for approval prior to an individual beginning the program.

(b) The preceptor shall maintain progress reports for an AIT on forms prescribed by the Board for each quarter of the required hours of the training program.

(c) The quarterly report shall be submitted to the Executive Director of the Board and shall include the following:

1. Subjects covered and hours spent in each department;

2. Comments on the monthly internship logs as to accuracy and completeness;

3. Progress of the AIT; and

4. Identification of problems, if any.

(d) The AIT shall maintain monthly logs of work activities which shall be submitted quarterly to the Executive Director of the Board.

(e) The AIT shall co-sign and submit the quarterly progress reports to the Executive Director of the Board.

(f) Each quarterly report shall be submitted to the Board within 15 working days of the end of the quarter evaluated.

(g) The verification of program completion forms shall be completed, signed by the preceptor for the AIT or assistant administrator, and submitted to the Board within 15 working days of the completion of the program.

(h) If a preceptor fails to submit the report(s) required in a timely manner as indicated in N.J.A.C. 8:34-4.5(f) and 8:34-4.5(g) above, the AIT may be required to forfeit all credit for the training accumulated on the report(s) for that period.

SUBCHAPTER 5. EXAMINATION

8:34-5.1 Examination requirements

(a) The examination shall be the licensing examination approved by the Board.

(b) An applicant for licensure as an AIT or assistant administrator shall complete all the application requirements identified at N.J.A.C. 8:34-3.2 before being permitted to take the written examination.

8:34-5.2 Scheduling of examinations

Examinations shall be held at the discretion of the Board in accordance with the prevailing practice of the National Association of Boards, 808 17th Street, Suite 200, Washington, D.C. 20006.

8:34-5.3 Examination fee

An applicant shall be required to submit an examination fee at the time of the examination. The examination fee shall be determined by the Board, as set forth in N.J.A.C. 8:34-9.1(a)5.

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8:34-5.4 Subjects for examination

The subject matter for examination shall include, but not be limited to, the areas of: Resident Care Management; Personnel Management, Financial Management; Environmental Management; Regulatory Management; and Organizational Management.

8:34-5.5 Exclusion of examination subjects

Nothing contained in this rule shall preclude the Board from administering an examination which excludes subjects for examination which are in derogation of, or in conflict with, the teachings and practices of any recognized faith; provided however, that any applicant seeking entrance to such an examination shall submit evidence satisfactory to the Board that he or she is, in fact, an adherent of such recognized religious faith.

8:34-5.6 Grading of examinations

The Board shall establish the passing grade for each license examination administration. Each candidate for a nursing home administrator license shall be required to pass the examination, by meeting or exceeding the grade established by the Board for that particular examination.

8:34-5.7 Records of examination

Following the close of every examination, a record stating in detail the result of the examination for each candidate shall be maintained by the Department permanently.

8:34-5.8 Re-examination

(a) An applicant who fails the licensing examination, will be permitted to take a re-examination, in accordance with (b) through (f), below.

(b) Following a first examination failure, an applicant shall be permitted to sit for re-examination, upon approval by the Board, based upon the application requirements contained in this chapter.

(c) Following a second examination failure, or any subsequent examination failures, an applicant shall take 50 hours of remediation approved by the Board or its designee, before the applicant is permitted to take a re-examination.

(d) If an applicant fails to pass the second licensing examination, or any subsequent licensing examination, the applicant shall be required to submit to the Board, at least 30 days prior to the next examination the applicant will take, documentation of having completed 50 hours of remediation in the areas specific to the individual's deficits, or as approved by the Board.

(e) Written documentation of successful completion of the remediation provided for at N.J.A.C. 8:34-5.8(c) shall be submitted to the Executive Director of the Nursing Home Administrators Licensing Board, New Jersey State Department of Health, CN 367, Trenton, New Jersey 08625-0367, at least 30 days prior to the examination.

(f) If an applicant fails to pass the third licensing examination, or any subsequent licensing examination, in addition to completing 50 hours of remediation as set forth at N.J.A.C. 8:34-5.8(c), the candidate shall be required to complete 450 hours of administrative experience as an AIT or assistant administrator in a nursing home or a facility with licensed long term care beds, prior to taking the next examination, and submit documentation of completion of this requirement to the Executive Director of the Board, at least 30 days prior to the examination.

8:34-5.9 Conditional admission to examination

(a) At the Board meeting preceding the administration of an examination, the Board may agree to allow an applicant to sit for examination if the applicant, by the date of the examination, will have met all the prerequisites to sit for examination.

(b) An applicant allowed to sit for examination in accordance with (a) above shall submit written evidence of completion of the qualification requirements to the Board, or its designee, at least five working days before the date of examination. The applicant shall not be permitted entrance to the examination if he or she has not submitted evidence of completion of requirements.

8:34-5.10 Ineligibility

(a) An applicant who has been disqualified from admission to an examination shall be given written notification by the Board of his or her disqualification and the reasons therefor.

(b) An applicant who has been disqualified may petition the Board in writing, within 30 days of notification of disqualification, for a hearing and a review of the application as set forth in N.J.A.C. 8:34-8.3 and 8.4.

(c) When an applicant for examination has been disqualified, the applicant shall submit a new application to qualify for examination. The applicant shall meet the requirements for examination and licensing in force at the time of such reapplication.

SUBCHAPTER 6. LICENSURE

8:34-6.1 Granting of license

(a) The Board shall authorize the issuance of a nursing home administrator license to an individual who has complied with the provisions of this chapter.

(b) An individual who fails to comply with the provisions of this chapter shall not be issued a license.

(c) A license shall be issued for a period of no more than two years.

(d) A license shall not be transferable or assignable.

8:34-6.2 Renewal of license

(a) All licenses issued under this chapter shall expire on the date established by the Board and shall become invalid if not renewed.

(b) The Department shall issue a renewal license to a licensed administrator every two years upon review by the Department of the following:

1. The licensee shall submit a completed licensure renewal application; and

2. The licensee shall submit the required license renewal fee as determined by the Board in accordance with N.J.A.C. 8:34-9.1(a); and

3. The licensee shall submit written documentation of the completion of 40 hours of continuing education approved by the Board in accordance with N.J.A.C. 8:34-7.2(a).

(c) At the discretion of the Board or its designee, a license may be renewed up to 60 days after the date of its expiration upon payment of a late fee, as set forth at N.J.A.C. 8:34-9.1(a)4, in addition to the renewal fee.

(d) An applicant for licensure renewal, who had a license issued by the Board for less than two years, shall be required to complete at least the following number of continuing education hours:

1. Licensed for 19 to 24 months..... 40 hours;
2. Licensed for 12 to 18 months..... 30 hours;
3. Licensed for 6 to 11 months..... 20 hours;
4. Licensed for less than 6 months..... 0 hours.

8:34-6.3 Use of the title, "Licensed Nursing Home Administrator"

(a) An individual who holds a valid license pursuant to the provisions of these rules shall have the right and privilege of using the title "Licensed Nursing Home Administrator" and have the right and privilege of using the abbreviation "L.N.H.A." after his or her name.

(b) Use or designation by title or abbreviation, or any other words, letters, sign, card or device intending to indicate that a person is a licensed nursing home administrator, by any person not so licensed, shall be prohibited.

8:34-6.4 Display of license

An individual licensed as a nursing home administrator shall display such license in a conspicuous place in the nursing home where the individual is employed.

8:34-6.5 Duplicate license

Upon receipt by the Board of a notarized statement from the licensed nursing home administrator that a license has been lost, mutilated, stolen, or destroyed, the Department may issue a replacement license upon payment of the appropriate fee as required at N.J.A.C. 8:34-9.1(a) and under such conditions as the Board may prescribe.

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8:34-6.6 Change of name

If a licensed nursing home administrator changes his or her name, the name change shall be recorded in the register for licensed administrators. The licensed administrator shall submit documentation to the Department of the change of name and a certified copy of the court order or marriage certificate. When a duplicate license is issued, the original license shall be returned to the Department.

8:34-6.7 Change of address and employment

(a) A licensed administrator shall notify the Board in writing within ten working days of any change in his or her home address.

(b) A licensed administrator shall notify the Board in writing within ten working days of any change in his or her place of employment.

8:34-6.8 License by equivalency

(a) An individual licensed in good standing as a LNHA in another jurisdiction may request approval of the Board for issuance of a New Jersey license by equivalency. The Board may approve the application only where it finds that the educational, training, and administrative experience requirement, and passing scores in the licensing examination, are equal to those required in the State of New Jersey at the time the applicant received his or her license in the other jurisdiction.

(b) An individual who fails to comply with the requirements for licensure of this chapter may be issued a license if the individual has been employed as a long term care administrator, in an out-of-State licensed long term care facility for at least one year, full time, within no more than the two years prior to submission of an application for license by equivalency.

(c) An individual applying for licensure by equivalency, shall submit to the Board:

1. A completed nursing home administrator application form; and
2. An application fee as set forth in N.J.A.C. 8:34-9.1(a)1; and
3. Verification of out-of-State licensure form(s) completed by the State Board in all states in which the individual may have at any time held a license to practice as a nursing home administrator, providing evidence satisfactory to the Board of the individual's good standing as a nursing home administrator in the jurisdiction which issued the license; and
4. Three written references attesting to the administrative ability and character of the individual; and
5. A background check by the New Jersey State Police.

8:34-6.9 Inactive status

(a) If a licensed administrator fails to fulfill the license renewal requirements at the prescribed time, in accordance with N.J.A.C. 8:34-6.2, the license shall be considered inactive.

(b) An individual may apply for license without re-examination within two years of the license renewal date and upon submitting a request for restoration of said license, in writing, to the Board.

(c) An individual requesting restoration of his or her license from inactive status within two years of inactivity, shall be required to pay the current license renewal fee in accordance with N.J.A.C. 8:34-9.1(a)3 and comply with the education requirements identified at N.J.A.C. 8:34-6.9(d) below.

(d) The applicant shall be required to complete 40 hours of continuing education credit for each year in which the license was inactive in addition to the required 40 hours of continuing education for biennial licensing period.

(e) An administrator whose license is in an inactive status and who subsequently fails to meet the requirements identified at N.J.A.C. 8:34-6.9(b), (c), and (d), shall be required to apply in writing for restoration of licensure under the requirements as determined by the Board on an individual basis and as provided for in these rules.

SUBCHAPTER 7. CONTINUING EDUCATION

8:34-7.1 Purpose and scope

The requirements set forth under this subchapter shall apply to all Board licensees eligible to practice long term care administration within the State of New Jersey except where the rules provide for exemption or waiver.

8:34-7.2 Licensure renewal continuing education credit requirement

(a) By the completion of each biennial licensing period, each administrator shall, as a condition of licensure renewal identified at N.J.A.C. 8:34-6.2 successfully complete 40 hours of approved continuing education in health or health-related courses, seminars, or programs relevant to long term care administration as determined by the Board.

(b) Attendance at meetings of, and/or service for, professional trade associations and associations of licensed administrators approved by the Board, may yield up to ten hours of continuing education credits every two years.

(c) Each licensee shall be permitted to carry over up to five excess credit hours from one licensing period to the next.

8:34-7.3 Waiver of continuing education credits

(a) The Board or its designee may, for good cause to be determined by the Board or its designee, in accordance with N.J.A.C. 8:34-1.8, waive all or part of the continuing education requirement for the licensing period. All such requests to the Board by the licensee shall be in writing and accompanied by written documentation supporting the reasons for the request.

(b) Waivers shall be granted for one licensure period at a time. If the situation for which the waiver was granted continues, the licensee shall reapply in writing to the Board for a renewal of the waiver.

8:34-7.4 Extension of time

(a) The Board or its designee may, for good cause to be determined by the Board, grant an extension of time the licensee shall have to complete the continuing education requirement for the two year licensure period. All such requests to the Board by the licensee shall be in writing and accompanied by written documentation supporting the reasons for the request.

(b) Extension letters with a date of expiration shall be issued by the Board and shall serve as verification that the individual remains licensed during this period of time. Upon completion of the required continuing education hours within the prescribed period of time, a license shall be issued.

8:34-7.5 Continuing education criteria

(a) Criteria for continuing education courses shall include:

1. Professional competency and ethics, as well as legal aspects relating to the practice of long term care administration; and
2. Material designed to acquaint administrators with the utilization and application of new techniques relating to long-term care administration.

(b) The Board shall develop and promulgate standards for determining which, if any, out-of-State courses, seminars, or programs qualify for the credit hour requirement for licensure identified at N.J.A.C. 8:34-7.2(a).

(c) The Board shall review and monitor all approved courses, seminars or programs. Upon evidence that the courses, seminars or programs fail to meet the criteria in this chapter, the sponsoring institution or agency shall lose its approved status and shall be required to reapply for future continuing educational approval.

8:34-7.6 Program approval

(a) Any course of study offered by an educational institution, association, professional society, person or organization for the purpose of qualifying applicants for licensing in this State as nursing home administrators and/or for license renewal shall require the approval of the Board.

(b) Any person or organization desiring approval as a sponsor of a health or health-related course, seminar, or program shall apply to the Board through written application. Such written application shall be received by the Board at least 60 days prior to the date of the Board meeting at which approval is requested and shall include at least the following:

1. Dates that the course, seminar or program is to be offered;
2. The objectives and content of the course, seminar or program;

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3. The total hours of instruction and credit; and
4. The names and resumes of instructors.

(c) All sponsors shall secure Board approval prior to representing that the course, seminar or program fulfills the requirements of this subchapter.

(d) Board approval of a course, seminar or program shall be considered valid for one year from date of approval, provided that the items identified at N.J.A.C. 8:34-7.6(b)2-4 remain unchanged during the one-year time period.

(e) Notice of the date, time and place the course is to be offered shall be provided to the Board if the course is offered additional times during the one year approval period.

8:34-7.7 Record of continuing education credits

(a) An applicant for licensure or licensure renewal shall be required to maintain appropriate documentation of course, seminar or program attendance.

(b) An applicant for license renewal shall submit to the Board verification of continuing education hours accumulated by the licensee. Verification material shall be appropriate evidence of the successful completion of an approved course, seminar or program, in the form of a certificate or similar official record of attendance signed by the approved sponsor.

(c) An applicant for license renewal shall complete the appropriate licensure renewal forms by listing under continuing education information all the approved courses, seminars or programs which the applicant completed, as well as the number of credits earned, for the renewal period in question.

SUBCHAPTER 8. SUSPENSION, REVOCATION AND HEARINGS

8:34-8.1 Suspension and revocation

A nursing home administrator whose license is either suspended or revoked, pursuant to N.J.S.A. 25:2H-27 and 26:2H-28 (Chapter 356, P.L. 1968), shall not be appointed or retained in the facility in any administrative, managerial, supervisory, or similar position.

8:34-8.2 Denial, license suspension, or license sanctions

(a) The Board may refuse to issue a license, recommend to the Commissioner the revocation or suspension of a license, or may reprimand or otherwise discipline an individual, in accordance with N.J.A.C. 8:34-8.2(d), upon receiving substantial evidence that said individual for license or registration, or such nursing home administrator:

1. Has violated any of the provisions of the law pertaining to the licensing of nursing home administrators or the rules of the Department pertaining thereto;
2. Has willfully or repeatedly violated any of the provisions of N.J.S.A. 26:2H-1 et seq. or the rules of any licensing or supervising authority or agency of the State or political subdivision thereof having jurisdiction over the operation and licensing of nursing homes;
3. Has been convicted of a crime involving moral turpitude or of violating the provisions of N.J.S.A. 30:11-11 or these rules by a court of competent jurisdiction or has admitted such guilt;
4. Has practiced fraud, deceit, or misrepresentation in securing or procuring a nursing home administrator license;
5. Is incompetent to engage in the practice of nursing home administration or to act as a nursing home administrator;
6. Has practiced fraud, deceit, or misrepresentation in his/her capacity as a nursing home administrator;
7. Has committed acts of misconduct in the operation of a nursing home under his/her jurisdiction;
8. Is addicted or dependent upon the use of any drug recognized as resulting in abnormal behavior;
9. Has practiced without a nursing home administrator license;
10. Has wrongfuly transferred or surrendered possession either temporarily or permanently of his/her license to any person;
11. Has paid, given, caused to be paid or given or offered to pay or give to any person a commission or other valuable consideration for the solicitation or procurement either directly or indirectly of nursing home patronage;
12. Has been guilty of fraudulent, misleading, or deceptive advertising;
13. Has impersonated another licensee of a like or different name;
14. Has failed to act to promote the safety, health and life of a patient(s);
15. Has willfully permitted unauthorized disclosure of information relating to a patient or his or her records;
16. Has discriminated in respect to residents, employees or staff on account of race, religion, color, sex or national origin;
17. Has committed an act of professional negligence or omission of professional responsibility that is repeated, willful or knowingly committed, or has committed gross negligence, in the opinion of the Board; or
18. For such other reasons as the (State) Board might deem reasonable and appropriate to protect the health, safety and welfare of the residents of any nursing home.

(b) The Board shall refuse to issue a license, recommend the revocation or suspension of a license, or reprimand an individual only after the individual has been afforded due notice and the opportunity to be heard in accordance with N.J.S.A. 30:11-17.

(c) Pursuant to N.J.S.A. 30:11-21, the Board shall have the right of inquiry into the operations of a facility and review of statement of deficiencies and penalties issued by the Department in accordance with this chapter and pursuant to N.J.S.A. 30:11-21.

(d) Pursuant to N.J.S.A. 30:11-21(e) the Board shall have the power to:

1. Request an administrator to appear before the Board;
2. Place a letter of reprimand in the Department file of an administrator;
3. Place a letter of censure or warning in the Department file of an administrator;
4. Require an administrator to complete continuing education credits in specified areas in addition to the CEUs required for licensure renewal;
5. Require an administrator to obtain counseling and assistance;
6. Recommend the issuance of a civil penalty; and/or
7. Recommend to the Commissioner, the denial, suspension or revocation of an administrator's license to the Commissioner.

8:34-8.3 Hearings

(a) Any person, public officer, association, or the Department, may prefer charges against a licensee for due cause. Such charge shall be in writing and shall be submitted to the Board.

(b) The Board shall review the charges and retain the authority to dismiss said charges and take no action thereon, by formal hearing or otherwise, in which case the complaint and supporting documentation shall be filed with the Department.

(c) The Board may elect to issue a recommendation of revocation, suspension, or denial of a license, in which case the Board shall forward notice of its recommendation, together with a specification of charges, to the applicant or licensee by registered mail.

(d) Revocation, suspension, reprimand, or denial shall become effective 30 days after mailing of notice unless the applicant or licensee, within said 30 day period, shall give written notice to the Department of a desire for a hearing.

(e) If a hearing is requested by the applicant or licensee, the revocation, suspension, reprimand, or denial action shall be held in abeyance until final adjudication of the complaint.

(f) An order of suspension, denial, or revocation may contain such provisions regarding reinstatement of the license as the Board shall recommend. In the absence of any such provisions regarding reinstatement in an order of revocation, the revocation shall be deemed to be permanent.

8:34-8.4 Conduct of hearings

(a) The applicant or licensee shall be afforded an opportunity for a prompt and fair hearing before a final decision is made on the matter of revocation, suspension, reprimand or denial of any license. The procedure governing such hearing shall be in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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(b) The Commissioner shall render a written decision stating conclusions and reasons therefor upon each matter heard, and shall be empowered to enter orders of revocation, suspension or denial consistent with the circumstances in each case.

8:34-8.5 Restoration and reinstatement of licenses

(a) Upon written application for restoration of a license, the Board in its discretion may grant the applicant a hearing upon notice.

(b) If conviction of a crime which resulted in the revocation or suspension of a license is subsequently reversed on appeal and the accused acquitted or discharged, the license shall be restored, upon written request by the licensee to the Board.

SUBCHAPTER 9. FEES

8:34-9.1 Fees and charges

(a) The following fees shall be paid by the applicant:

1. Application fee ..... $100.00
2. Original license fee
   i. During the first year of a biennial renewal period... 150.00
   ii. During the second year of a biennial renewal period ..... 75.00
3. Biennial license renewal fee ..... 150.00
4. Late renewal fee in addition to renewal fee ..... 25.00
5. Duplicate license fee ..... 10.00
6. Duplicate certificate fee ..... 10.00
7. License restoration fee ..... 175.00
8. Annual fee for submission of a continuing education program application to be approved by the Board ..... 25.00
   i. State agencies shall be exempt from the payment of this fee.

(b) Prior to taking the licensure examination, each applicant shall be required to submit an examination fee in the amount specified by the professional examination service utilized by the Department for the administration of the examination and approved by the Department and the Nursing Home Administrator's Board in accordance with N.J.S.A. 30:11-13. The Department shall provide timely notice of the examination fee in the Public Notices section of the New Jersey Register.

(c) All fees collected under the provisions of this subchapter are non-refundable.

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# (a)

## DIVISION OF HEALTH FACILITIES EVALUATION

## Standards for Licensure of Assisted Living Residences and Comprehensive Personal Care Homes

## Proposed New Rules: N.J.A.C. 8:36

Authorized By: Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Proposal Number: PRN 1993-446.

Submit comments by September 15, 1993 to:
John A. Calabria, Program Manager
Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625-0367

The agency proposal follows:

**Summary**

The Department is proposing the adoption of the Manual of Standards for Licensure of Assisted Living Residences and Comprehensive Personal Care Homes. (Please see related Certificate of Need rules proposal, elsewhere in this issue of the New Jersey Register.) These two types of Assisted Living facilities are intended to promote "aging in place" in a homelike setting for frail elderly and disabled individuals, including those who may require formal long term care services as they age. Such facilities will offer supportive personal care and health services to enable residents to maintain independence, individuality, privacy, and dignity in an apartment-like setting. This kind of living environment is being developed to enhance resident self direction and personal decision-making while assuring residents' rights, safety and health. It is anticipated that these facilities will serve as an attractive alternative to licensed long-term care facilities.

Implementing the concept of "aging in place" will enable residents to choose a residential setting with the assurance that they may reside there with a great deal of independence without having to transfer to a more formal and less homelike institution as they age and their frailties and personal and health care needs increase. Assisted living facilities will be able to offer a wide range of living arrangements and will be capable of providing care to residents with differing disabilities, frailties, and strengths. However, this kind of living environment is not intended for persons who are no longer capable of responding to their environment, expressing volition, interacting or demonstrating independent activity. These proposed rules require each facility licensed to offer assisted living services to specifically define in their admission agreement the kinds of health care services provided, to what extent, and at what additional cost, if any.

Assisted Living Residences will consist almost exclusively of newly constructed or extensively renovated buildings that are capable of complying with all the proposed rules herein, including Physical Plant and Environment. Assisted living residences will offer apartment-style units in a variety of settings (for example, cottages, high-rise buildings, Victorian-style mansions), to meet the needs of frail elderly and disabled residents. In order to make use of an existing supply of beds and facilities, these rules permit existing, licensed long-term care, residential health care and Class C Boarding Homes to offer assisted living services and convert their licenses to Comprehensive Personal Care Homes. This not only takes advantage of existing physical facilities but also permits persons currently residing in them to utilize the concept of aging in place. Comprehensive Personal Care Homes will be required to comply with all the operational and service requirements of these rules, including the provision of health care services, but will not be required to meet all physical plant standards.

The first subchapter defines terms used throughout the manual and specifies the qualifications required of various categories of personnel. It also describes the scope and purpose of these rules.

Subchapter 2 describes licensure procedures which are similar to those for other types of licensed health care facilities. The fee schedule proposed at N.J.A.C. 8:36-2.2(d) requires a licensing fee of $500.00 plus $10.00 per residential unit.

Subchapter 3 defines physical plant standards required for Assisted Living Residences. Comprehensive Personal Care Homes will be expected to comply with these standards within the constraints imposed by their current physical plant. It should be noted that, unlike currently licensed health care facilities, proposed N.J.A.C. 8:36-3.8(c) requires that units be lockable by the resident; 8:36-3.9 requires individual toilets and baths; and 8:36-3.10 requires a kitchenette in each unit.

Subchapter 4 lists various General Requirements which are similar to those for other licensed health care facilities. It must be noted that proposed N.J.A.C. 8:36-4.1(d)1, 4.6(a)2, and 4.12 deal with providing each resident with a clear description of the services that the facility will and will not provide and the circumstances under which a resident may no longer be retained. Proposed N.J.A.C. 8:36-4.5 describes minimum staffing requirements. These modest requirements are intended to emphasize that facilities licensed to offer assisted living are not intended to operate along the lines of a medical model. In addition, these staffing requirements permit facilities to staff according to the actual needs of the residents rather than according to a pre-set staffing ratio.

Subchapter 5 describes the responsibilities of the administrator.

Subchapter 6 requires written policies and procedures for resident care and describes the steps to be taken to secure resident finances.

Requirements for resident assessments, service and health care plans and the provision of health care services are defined in Subchapter 7. All resident assessments are required to be performed by a registered professional nurse. The resident service plan is based on this assessment. If the assessment indicates the resident has health care needs, a health care assessment must be completed by the registered professional nurse within 14 days of admission to the facility. This health care assessment will serve as the basis of the health care plan, including any additional staffing requirements.

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Subchapter 8 concerns dining services and includes the designation of a food service supervisor and various specific requirements for dining services. It also describes the responsibilities of a dietitian, if one is required based on resident needs.

Subchapter 9 addresses the provision of pharmaceutical services. Resident safety is the objective of these rules. Proposed N.J.A.C. 8:36-9.2 and 9.3 describe the procedures for self-administered and staff administered drugs respectively. The designation of a pharmacist to assist the facility is required at proposed N.J.A.C. 8:36-9.4.

The provision of a program of resident activities is required in Subchapter 10, while Subchapter 11 requires the facility to arrange for social work services for all residents whose service plan indicates such services are needed.

Subchapter 12 addresses emergency services and procedures. Proposed N.J.A.C. 8:36-12.2 requires the development of written emergency plans, policies and procedures. Proposed N.J.A.C. 8:36-12.3 describes the requirements for periodic drills and tests of the emergency plans and procedures.

The intent of subchapter 13 is to ensure that a complete record is developed and maintained for each resident and that this record, while accessible to staff and resident, is kept confidential. Particular required components of the facility register are described at N.J.A.C. 8:36-13.1(d)1, while the necessary components of the resident record are listed at N.J.A.C. 8:36-13.1(d)2.

Subchapter 14 enumerates various resident rights for residents. Specific rights include the fostering of independence and individuality, the right to make choices with respect to services and lifestyle, and the right to privacy.

Subchapter 15 includes a list of housekeeping, sanitation, safety and maintenance requirements. Proposed N.J.A.C. 8:36-15.5(a) 4 requires that residents of assisted living residences be able to regulate temperature controls in residential units, as is the norm in most private apartments.

The infection prevention and control activities identified in subchapter 16 are designed for both resident and staff safety. They are similar, though less expansive, to the requirements for other types of health care facilities.

Subchapter 17 describes those licensed facilities that are eligible for licensure as a Comprehensive Personal Care Home. This subchapter also details which specific preceeding subchapters and sections are also applicable to Comprehensive Personal Care Homes, as well as describing the specific physical plant requirements for such homes.

**Social Impact**

The Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., bestows upon the Department of Health the responsibility to protect and promote the health of the citizens of this State. The act also mandates the Department to develop "standards and procedures relating to the licensing of health care facilities and the institution of additional health care services" to ensure the efficient and effective delivery of health care services.

The Department expects that the proposed rules will provide an effective and more homelike alternative to long term care facilities. The intent is to provide a setting that will enhance the independence and quality of life of the residents who choose this alternative. Care was taken in rule development to ensure that the standards do not impose unnecessary restrictions on residents and that they do not foster the development of a "medical model" of care delivery. In this regard it should be noted that the rules do not require routine round-the-clock nursing care. Rather, the presence of a registered nurse will be determined by the development and implementation of a health care plan. However, the registered professional nurse must be on call 24 hours per day. Additionally, the rules are most specific in areas related to the provision of health care services and less prescriptive in other areas.

The development of Assisted Living Residences and Comprehensive Personal Care homes will enable residents to "age in place" without the necessity to undergo a transfer to another facility as frailties and most health care needs increase. Thus, these new kinds of facilities are expected to be an attractive alternative living arrangement for many New Jersey residents.

The proposed rules have also been developed to provide maximum flexibility in service provision to facility operators. This will not only help to contain costs but will also enable providers to offer a number of different living arrangements and service packages to residents.

**Economic Impact**

Assisted Living Residences and Comprehensive Personal Care Homes provide a means by which health care costs may be contained. They are intended to serve as an alternative to institutional long term care services which are organized and staffed along a "medical model." The proposed rules are intentionally not as stringent or as costly as those for licensed long term care facilities, particularly in the area of staffing. To the extent that the new kinds of facilities are less costly than long term care facilities, both the public and third party payors, including Medicaid, should benefit.

It is anticipated that Assisted Living Residences will be newly constructed or extensively renovated buildings that will comply with all the physical plant requirements in subchapter 3. Since some Assisted Living Residences will construct to comply with the minimum standards contained in these rules, while others will construct in excess of these minimums, it is not possible at present to estimate an average construction cost.

Depending on their current physical plant, there may be additional costs for existing facilities, particularly residential health care facility and "Class C" boarding homes, to convert to a Comprehensive Personal Care Home. This will be the case if the existing physical plant does not comply with the requirements proposed at N.J.A.C. 8:36-17.3.

A listing of those requirements which may result in a cost to the regulated entities follows:

N.J.A.C. 8:36-2.2(d) specifies the licensing fees of $500.00 plus $10.00 per residential unit.

N.J.A.C. 8:36-2.7 provides for requests for waivers of certain requirements, documented appropriately. An applicant may elect to seek assistance in the preparation of waivers and may thus incur an expense. Documentation submitted in support of the waivers would be based upon the individual situation.

The appeal of an action against a licensee may entail costs for professional services, such as those of an attorney; however, such services are not specifically required by the rules. The rules encourage settlement with the Department through conference; however, should the issue be referred to the Office of Administrative Law as a contested case, costs of the hearing would be incurred by the Department and the facility contesting.

Subchapter 4 requires the development of job descriptions, policies and procedures, and reporting requirements which will create costs for the licensee. These costs will vary with facility size and scope of services provided. The reporting requirements involve only telephone and mail contacts and should entail minimal expense.

The various physical plant requirements contained in subchapters 3 and 17 each impose a cost; however, the amounts cannot be determined for the entire regulated public, since each licensee is expected to implement the requirements in a unique manner.

A number of the proposed rules may have a direct financial benefit for residents of the facilities. For instance, the provisions at N.J.A.C. 8:36-6.2(a) requiring full disclosure of fees upon admission and when fees or charges change will help to financially protect residents. The next section, N.J.A.C. 8:36-6.3, requires the facility to develop policies and procedures for handling the personal needs allowance of eligible residents.

**Regulatory Flexibility Analysis**

The rules in this chapter will apply to two new kinds of licensed entities: Assisted Living Residences and Comprehensive Personal Care Homes. It is not possible to accurately estimate how many new Assisted Living Residences will be constructed or how many currently existing facilities will convert to Comprehensive Personal Care Homes. However, it is expected that most, if not all, of these kinds of facilities will be considered small businesses, as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The proposed rules were written with the intention of simultaneously enhancing resident independence and quality of life, while safeguarding resident health and safety without imposing unnecessary requirements on the facilities. Thus, while subchapter 7 lists requirements for health care assessments, plans, and services, these apply only to those residents who require such services. In a similar vein, subchapters 10 and 11, dealing respectively with resident activities and social work services, are very brief, requiring only that such services be provided, leaving flexibility to the facility in deciding how to provide them.

The Department maintains the general appropriateness and necessity of these rules for all Assisted Living Residences and Comprehensive

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Personal Care Homes regardless of size. Therefore, no differentiation based on business size has been provided in these rules.

**Full text** of the proposed new rules follows:

CHAPTER 36

STANDARDS FOR LICENSURE OF ASSISTED LIVING RESIDENCES AND COMPREHENSIVE PERSONAL CARE HOMES

SUBCHAPTER 1. DEFINITIONS AND QUALIFICATIONS

8:36-1.1 Scope

(a) The rules in this chapter pertain to all facilities which provide assisted living services. These rules constitute the basis for the licensure of assisted living residences and comprehensive personal care homes by the New Jersey State Department of Health.

(b) Assisted living residences shall comply with N.J.A.C. 8:36-1 through 16; comprehensive personal care homes shall comply with N.J.A.C. 8:36-17.

8:36-1.2 Purpose

(a) The purpose of these rules is to establish standards for assisted living residences and comprehensive personal care homes which are intended to promote "aging in place" in a homelike setting for frail elderly and disabled persons, including persons who require formal long-term care. Assisted living residences and comprehensive personal care homes assure that residents receive supportive health and social services as they are needed to enable them to maintain their independence, individuality, privacy, and dignity in an apartment-style living unit. The assisted living environment promotes resident self direction and personal decision-making while protecting residents' health and safety.

(b) An assisted living residence or comprehensive personal care home offers a suitable living arrangement for persons with a range of capabilities, disabilities, frailties, and strengths. In general, however, assisted living is not appropriate for individuals who are incapable of responding to their environment, expressing volition, interacting, or demonstrating any independent activity. For example, individuals in a persistent vegetative state who require formal long-term care should not be placed or cared for in an assisted living residence or comprehensive personal care home.

(c) The aim of this chapter is to establish minimum rules with which an assisted living residence or comprehensive personal care home must comply in order to be licensed to operate in New Jersey.

8:36-1.3 Definitions

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

"Activities of daily living (ADL)" means the functions or tasks for self-care which are performed either independently or with supervision or assistance. Activities of daily living include at least: mobility, transferring, walking, grooming, bathing, dressing and undressing, eating, and toileting.

"Aging in place" means a process whereby individuals remain in their living environment despite the physical and/or mental decline and growing needs for supportive services that may occur in the course of aging. For aging in place to occur, services are added, increased, or adjusted to compensate for the person's physical and/or mental decline.

"Assisted living" means a coordinated array of supportive personal and health services, available 24 hours per day, to residents who have been assessed to need these services, including residents who require formal long-term care. Assisted living promotes resident self direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

"Assisted living residence" means a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance.

"Assistance with transfer" means providing verbal and physical cuing or the physical assistance of no more than two facility staff or both while the resident moves between bed and a standing position or between bed and a chair or wheelchair.

"Available" means ready for immediate use (pertaining to equipment) or capable of being reached (pertaining to personnel), unless otherwise defined.

"Bedridden" means physically unable to rise from bed, even with assistance with transfer from the bed.

"Commissioner" means the New Jersey State Commissioner of Health.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

"Comprehensive personal care home" means a facility which is licensed by the Department of Health to provide room and board and to assure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance.

"Department" means the New Jersey State Department of Health.

"Documented" means written, signed, and dated.

"Employee" means a person who is gainfully employed in the assisted living facility on a full or part-time basis and for whom a record of hours worked and wages paid are maintained and who meets the health, age and other requirements of this chapter. Reimbursement for such employment may include salaries, wages, room and board, or any combination thereof. A person placed in the assisted living facility under a purchase of care or service agreement by the facility, or the resident, is not considered an employee.

"Formal long-term care" means ongoing assistance with activities of daily living and health care services, provided on a daily or regular basis to people with disabling long-term illnesses by nurses or other health care professionals or by personnel under the direction and supervision of health care professionals, as ordered by a physician.

"Full-time" means relating to a time period established by the facility as a full working week, as defined and specified in the facility's policies and procedures.

"Governing authority" means the organization, person, or persons designated to assume legal responsibility for the management, operation, and financial viability of the facility.

"Guardian" means a person appointed by a court of competent jurisdiction to handle the affairs and protect the rights of any resident of the facility who has been declared a mental incompetent. Guardian does not include a person affiliated with the facility, its operations or personnel, unless ordered by the court.

"Health care service" means any service provided to a resident of an assisted living residence or comprehensive personal care home that is ordered by a physician and required to be provided or delegated by a licensed, registered or certified health care professional. Any other service, whether or not ordered by a physician, that is not required to be provided by a licensed, registered or certified health care professional is not to be considered a health care service. For purposes of this definition a certified health care professional excludes certified homemaker/home health aide and certified nurse aides.

"Health care facility" means a facility so defined in N.J.S.A. 26:2H-1 et seq., and amendments thereto.

"Job description" means written specifications developed for each position in the facility, containing the qualifications, duties and responsibilities, and accountability required of employees in that position.

"Licensed nursing personnel" (licensed nurse) means registered professional nurses or practical (vocational) nurses licensed by the New Jersey State Board of Nursing.

"Nursing supervision" means services which are provided to a resident whose condition requires continued monitoring of vital signs and physical and cognitive status. Such services shall be medically

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complex enough to require ongoing assessment, planning, or intervention by a nurse; required to be performed by or under the supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or the disease state or stage.

"Personal care" means services supportive to residents' care and comfort, including, but not limited to, assistance with activities of daily living.

"Personal care assistant" means a person who is qualified in accordance with N.J.A.C. 8:36-1.8.

"Resident" means a person who lives in an assisted living residence or comprehensive personal care home.

"Residential unit" means a separate apartment or unit where one or more individuals reside within the assisted living residence or a room or rooms where residents reside within a comprehensive personal care home.

"Responsible person" means a person who has been designated by the resident and who has agreed to assist the resident, as needed, in arranging for health, social and financial services or making decisions regarding such services.

"Self administration" means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a resident to himself or herself. The complete procedure of self-administration includes removing an individual dose from a previously dispensed (in accordance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39), labeled container (including a unit dose container), verifying it with the directions on the label, and taking orally, injecting, inserting, or topically or otherwise administering the medication.

"Shift" means a time period defined as a full working day by the facility in its policy manual.

"Signature" means at least the first initial and full surname and title (for example, R.N., L.P.N., D.D.S., M.D., D.O.) of a person, legibly written with his or her own hand. A controlled electronic signature system may be used.

"Specialized care" or "specialized long-term care" means the care of individuals who must use a respirator or mechanical ventilator and the care of patients with severe behavior management problems, such as combative, aggressive, and disruptive behaviors.

"Staff education plan" means a written plan which describes a coordinated program for employee education for each service, including inservice programs and on-the-job training.

"Staff orientation plan" means a written plan for the orientation of each new employee to the duties and responsibilities of the service to which he or she has been assigned, as well as to the personnel policies of the facility.

"Supervision" means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his or her sphere of competence, with initial direction and periodic on-site inspection of the actual act of accomplishing the function or activity.

1. "Direct supervision" means supervision on the premises.

8:36-1.4 Qualifications of all staff

All staff shall be emotionally stable, be in good physical and mental health, be of good moral character, and exhibit a concern for the safety and well-being of residents.

8:36-1.5 Qualifications of the administrator of an assisted living residence or comprehensive personal care home

(a) The administrator of an assisted living residence or comprehensive personal care home shall:

1. Hold a current New Jersey license as a nursing home administrator, or be eligible to take the New Jersey Nursing Home Administrator's Licensing Examination, according to Department of Health requirements; or

2. Complete an Assisted Living training course approved by the Department of Human Services or other equivalent training as approved by the Department of Health, within one year of his or her employment as administrator; and

(b) The administrator of an assisted living residence or comprehensive personal care home shall participate at least annually in a minimum of at least 10 hours of continuing education regarding assisted living concepts, as specified and approved by the Department of Health or the Nursing Home Administrators Licensing Board.

(c) The owner of an assisted living residence who meets the qualifications listed in (a) above may also serve as the administrator.

8:36-1.6 Qualifications of dietitians

The dietitian shall possess a bachelor's degree from an accredited college or university with a major area of concentration in a nutrition-related field of study, and one year of full-time professional experience or graduate-level training in nutrition.

8:36-1.7 Qualifications of licensed practical nurses

Each licensed practical nurse shall be so licensed by the New Jersey State Board of Nursing

8:36-1.8 Qualifications of personal care assistants

(a) Each personal care assistant shall have completed:

1. A nurse aide training course approved by the New Jersey State Department of Health and shall have passed the New Jersey Nurse Aide Certification Examination; or

2. A Homemaker-Home Health Aide training program approved by the New Jersey Board of Nursing and shall be so certified by the Board.

(b) Each personal care assistant shall receive orientation prior to or upon employment and on-going inservice education regarding the concepts of assisted living.

8:36-1.9 Qualifications of pharmacists

Each pharmacist shall be so registered by the New Jersey State Board of Pharmacy.

8:36-1.10 Qualifications of physicians

Each physician shall be licensed or authorized by the New Jersey State Board of Medical Examiners to practice medicine in the State of New Jersey.

8:36-1.11 Qualifications of registered professional nurses

Each registered professional nurse shall be so licensed by the New Jersey State Board of Nursing.

8:36-1.12 Qualifications of social workers

Each social worker shall be licensed or certified by the New Jersey State Board of Social Work Examiners.

SUBCHAPTER 2. LICENSURE PROCEDURES

8:36-2.1 Certificate of Need

(a) According to N.J.S.A. 26:2H-1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, licensed to operate, or closed except upon application for, and receipt of, a Certificate of Need issued by the Commissioner.

(b) Application forms for a Certificate of Need and instructions for completion may be obtained from:

Certificate of Need Program
Division of Health Planning and Resources Development
New Jersey State Department of Health
CN 360
Trenton, New Jersey 08625-0360
609-292-6552

(c) The facility shall implement all conditions imposed by the Commissioner as specified in the Certificate of Need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with N.J.S.A. 26:2H-1 et seq., and amendments thereto.

8:36-2.2 Application for licensure

(a) Following receipt of a Certificate of Need, any person, organization, or corporation desiring to operate an assisted living residence shall make application to the Commissioner for a license on forms prescribed by the Department. Such forms may be obtained from:

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Director
Licensing and Certification & Standards
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625
609-588-7726

(b) Any long term care facility, residential health care facility, or Class "C" boarding home planning to provide assisted living services shall obtain licensing approval from the Department prior to initiating services.

(c) A copy of the assisted living residence or comprehensive personal care home admission agreement shall be forwarded to the Director, Licensing and Certification & Standards (see (a) above for address) for review when application for licensure is made. Review shall ensure that the admission agreement does not violate any requirements contained herein, any conditions placed on Condition of Need approval, or any applicable State or Federal statutes. Any subsequent changes to the admission agreement shall be submitted to the Department of Health for review.

(d) The Department shall charge a nonrefundable fee of $500.00 plus $10.00 per bed (for the maximum number of beds available) for the filing of an application for licensure of an assisted living residence and comprehensive personal care home and for the annual renewal of the license. The facility shall receive a license for the maximum number of beds available in its residential units.

(e) Each applicant for a license to operate a facility shall make an appointment for a preliminary conference at the Department with the Licensing and Certification Program.

8:36-2.3 Newly constructed or expanded facilities

(a) Any assisted living residence or comprehensive personal care home with a construction program, whether a Certificate of Need is required or not, shall submit plans to the Health Facilities Construction Services of the Department for review and approval prior to the initiation of construction.

(b) The licensure application for a newly constructed, renovated or expanded facility shall include written approval of final construction of the physical plant by:

Health Facilities Construction Services
Division of Health Facilities Evaluation and Licensure
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625-0367
609-588-7731

(c) An on-site inspection of the construction of the physical plant shall be made by representatives of Health Facilities Construction Services to verify that the building has been constructed in accordance with the architectural plans approved by the Department.

8:36-2.4 Surveys and temporary license

(a) When the written application for licensure is approved and the building is ready for occupancy, a survey of the facility by representatives of the Health Facilities Inspection Program of the Department shall be conducted to determine if the facility adheres to the rules in this manual.

1. The facility shall be notified in writing of the findings of the survey, including any deficiencies found.

2. The facility shall notify the Health Facilities Inspection Program of the Department when the deficiencies, if any, have been corrected, and the Health Facilities Inspection Program will schedule one or more resurveys of the facility prior to occupancy.

(b) A temporary license may be issued to a facility when the following conditions are met:

1. A preliminary conference (see N.J.A.C. 8:36-2.2(d)) for review of the conditions for licensure and operation has taken place between the Licensing and Certification Program and representatives of the facility, who will be advised that the purpose of the temporary license is to allow the Department to determine the facility's compliance with N.J.S.A. 26:2H-1 et seq., and amendments thereto, and the rules pursuant thereto;

2. The initial survey required by N.J.A.C. 8:36-2.4(a) results in a finding of substantial compliance with the requirements of this chapter.

3. The completed licensure application is on file with the Department;

4. The fee for filing of the application has been received by the Department;

5. A copy of the admission agreement is on file with the Department;

6. Written approvals are on file with the Department from the local zoning, fire, health, and building authorities;

7. Written approvals of the water supply and sewage disposal system from local officials are on file with the Department for any water supply or sewage disposal system not connected to an approved municipal system;

8. Survey(s) by representatives of the Department indicate the facility adheres to the rules in this chapter; and

9. Personnel are employed in accordance with the staffing requirements in this chapter.

(c) No facility shall admit residents to the facility until the facility has the written approval and/or license issued by the Licensing and Certification Program of the Department. Violators of this requirement will be subject to penalties for operating a facility without a license, pursuant to N.J.S.A. 26:2H-14.

(d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and resident records and conferences with residents.

(e) A temporary license may be issued to a facility for a period of up to six months, subject to renewal as determined by the Department.

(f) The temporary license shall be conspicuously posted in the facility.

(g) The temporary license shall not be assignable or transferable and shall be immediately void if the facility ceases to operate or if the facility ownership changes.

8:36-2.5 Full license

(a) A full license shall be issued on expiration of the temporary license, if surveys by the Department have determined that the facility is in substantial compliance with the requirements of this chapter, and is operated as required by N.J.S.A. 26:2H-1 et seq.

(b) A license shall be granted for a period of one year or less, as determined by the Department.

(c) The license shall be conspicuously posted in the facility.

(d) The license shall not be assignable or transferable, and it shall be immediately void if the facility permanently ceases to operate or if its ownership changes.

(e) The license, unless suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date. The facility will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department, or if the facility is more than 60 days delinquent in payment of a penalty issued pursuant to N.J.S.A. 26:2H-14.

(f) The license may not be renewed if local rules, regulations and/or requirements are not met, on a case by case basis.

8:36-2.6 Surrender of license

The facility shall notify each resident, the resident's physician, and any guarantors of payment at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of license. In such cases, the license shall be returned to the Licensing, Certification and Standards Program of the Department within seven working days after the voluntary surrender, revocation, non-renewal, or suspension of license.

8:36-2.7 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of N.J.S.A. 26:2H-1 et seq., and amendments thereto, and the rules in this chapter, waive sec-

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tions of these rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of residents or the public.

(b) A facility seeking a waiver of these rules shall apply in writing to the Director of the Licensing, Certification and Standards Program of the Department.

(c) A written request for waiver shall include the following:

1. The specific rule(s) or part(s) of the rule(s) for which waiver is requested;

2. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon adherence;

3. An alternative proposal which would ensure resident safety; and

4. Documentation to support the request for waiver.

(d) The Department reserves the right to request additional information before processing a request for waiver, depending upon the waiver requested.

8:36-2.8 Action against a license

(a) If the Department determines that operational or safety deficiencies exist, it may require that all admissions to the facility cease. This may be done simultaneously with, or in lieu of, action to revoke licensure and/or impose a fine. The Commissioner or his or her designee shall notify the facility in writing of such determination.

(b) The Commissioner may order the immediate removal of residents from a facility whenever he or she determines imminent danger to any person's health or safety.

(c) The provisions of (a) and (b) above shall apply to facilities with a temporary or provisional license and facilities with a full license.

8:36-2.9 Hearings

(a) If the Department proposes to suspend, revoke, deny, assess a monetary penalty, or refuse to renew a license, the licensee or applicant may request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) Prior to transmittal of any hearing request to the Office of Administrative Law, the Department may schedule a conference to attempt to settle the matter.

8:36-2.10 Advertisement of assisted living

Only facilities licensed as assisted living residences or comprehensive personal care homes may describe and offer themselves to the public as providing assisted living services and care or other similar services. Violation of this requirement shall constitute operation of a health care facility without a license, and shall be subject to penalty in accordance with N.J.S.A. 26:2H-14.

SUBCHAPTER 3. PHYSICAL PLANT AND ENVIRONMENT

8:36-3.1 Scope

(a) The standards in this subchapter shall apply to new construction of assisted living residences or alterations or renovations to existing buildings to create assisting living residences.

(b) Prior to approval of a certificate of need for a transfer of ownership, the Department may conduct a physical plant inspection of the facility to determine the extent of physical plant deficiencies, based upon current codes and standards.

1. A report of the physical plant inspection shall be provided to the prospective buyer and seller.

2. A plan of correction shall be submitted to the Department for all physical plant deficiencies.

(c) New buildings and alterations, renovations and additions to existing buildings for assisted living residences shall conform with the New Jersey Uniform Construction Code, N.J.A.C. 5:23-3.2, Use Group I-1 of the subcode.

8:36-3.2 Restrictions

Mixed use occupancy shall not be permitted in buildings classified as High Hazard (H), Factory (F) or Assembly (A-2) Use Groups.

8:36-3.3 Ventilation

(a) Means of ventilation shall be provided in accordance with BOCA National Building Code/1990 Section 706.0, either by windows or by mechanical ventilation for every habitable room. When provided by mechanical ventilation there shall be at least two air changes per hour.

(b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation with at least 10 air changes per hour.

(c) All hallway corridors and passageways shall have a minimum of two outside air changes per hour.

8:36-3.4 Exit access passageways and corridors

The width of passageways, aisles and corridors shall not be less than 44 inches of clear space.

8:36-3.5 Automatic fire detection system

(a) Smoke detectors shall be provided in all residents' bedrooms, living rooms, and "studio apartment" units, whether or not the facility contains a comprehensive automatic fire suppression system throughout.

(b) All fire detection systems shall be installed in accordance with BOCA National Building Code, 1990, Section 1017.0 and NFiPA 72 E.

8:36-3.6 Fire suppression systems

All facilities shall be provided with a fire suppression system in accord with section 1004.0 of the 1990 BOCA National Building Code.

8:36-3.7 Interior finish requirement

(a) Interior wall and ceiling finishes within unit enclosures shall be Class A (having a flame spread of 0-25 and smoke development 0-450 based on test results from NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials). In all other areas, interior wall and ceiling finishes shall be Class A or Class B (having a flame spread of 26-75 and smoke development 0-450).

(b) Interior floor finishes in corridors, stairways and exits shall be Class I or Class II (critical radiant flux, minimum of 0.45 W/sq. cm. or 0.22 W/sq. cm. respectively, based on test results from NFPA 253, Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source).

8:36-3.8 Minimum Unit Size

(a) Residential units occupied by one person shall have a minimum of 150 square feet of clear floor area. ("Clear floor area" means space exclusive of vestibule, closets, bathroom and kitchenette.)

(b) In units occupied by more than one resident, there shall be a minimum of 80 additional square feet of clear floor area for each additional occupant.

(c) Residential units shall be lockable by the occupant(s). Egress from the unit must be possible at all times and locking hardware shall enable occupant(s) to gain egress from within by means of a simple operation. All residential units shall be accessible by means of a master key or similar system which is available at all times in the facility, and available at all times for use by designated staff.

(d) Each residential unit shall have an exterior glazed area equal to at least eight percent of the clear floor area.

8:36-3.9 Toilets, baths and handwashing sinks

(a) A bathroom with a toilet, bathtub and/or shower, and handwashing sink shall be located in each residential unit.

(b) Additional toilet facilities shall be provided to meet the needs of residents, staff and visitors to the facility and shall be located in areas other than the residential units.

8:36-3.10 Kitchenettes

(a) Each residential unit shall contain, at a minimum, a small refrigerator, a cabinet for food storage, a small bar-type sink, and space with electrical outlets suitable for small cooking appliances, for example, a microwave, a two-burner cooktop, or a toaster-oven.

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1. Upon entering the assisted living facility, the resident and the resident's family or representative shall be asked if they wish to have a cooking appliance. If so, the appliance shall be provided by the facility, in accordance with facility policies. If the resident and resident's family or representative wish to provide their own cooking appliance, it shall meet the facility's safety standards.

2. If the resident and resident's family or representative do not want a cooking appliance or if resident assessments indicate that having a cooking appliance in the living unit endangers the resident, no cooking appliance shall be provided or allowed in the living unit.

8:36-3.11 Community space

The facility shall provide a minimum of 30 square feet per resident of community spaces for dining and for active and passive recreation.

8:36-3.12 Laundry equipment

(a) Each assisted living facility shall provide at least one non-commercial washer and dryer for residents' personal items.

(b) Where laundry equipment is limited to non-commercial type (ordinary household or residential types), no special fire protective measures shall be required.

(c) When commercial type laundry equipment is utilized, it shall be installed in a separate laundry room. The remainder of the home shall be protected from the laundry room by partitions and openings of at least one-hour fire-resistance rating. Doors to such laundry rooms shall be protected in accordance with N.J.A.C. 8:36-3.7(b).

(d) All dryers shall be vented to the outside of the building.

8:36-3.13 Dietary department

(a) Construction, equipment, and installation of food service facilities shall meet the requirements of the dietary programs.

(b) The following facilities shall be provided, at a minimum:

1. A control station for receiving food supplies;
2. Minimum storage facilities for four days' food supply, including refrigeration and freezer for cold storage items;
3. Food preparation facilities;
4. Handwashing facilities located in the food preparation area;
5. Facilities for food distribution to residents;
6. Warewashing space;
7. Potwashing facilities and facilities for cart washing;
8. Storage areas for cans and carts;
9. Waste storage facilities;
10. Offices or desk space for dietitian(s) and the dietary service manager;
11. Janitor's closet; and
12. Self-dispensing icemaking facilities.

8:36-3.14 Administration and public areas

(a) A grade level entrance, sheltered from the weather and able to accommodate wheelchairs shall be provided, and shall include a reception and information counter or desk and waiting space.

(b) Space for private interviews shall be provided.

(c) An individual mailbox for each resident shall be provided.

(d) General or individual offices for records, administrative and professional staffs shall be provided.

(e) Space shall be provided for storing employee's personal possessions.

(f) Separate space shall be provided for storage of office supplies, sterile or pharmaceutical supplies, and housekeeping supplies.

(g) A room(s) for examination and treatment of residents, which is adequate for an overnight stay and includes toilet facilities, may be provided. It shall have a minimum floor area of 100 square feet, excluding space for vestibule, toilet and closet. It shall contain a lavatory or sink equipped for handwashing, a work counter, storage facilities, and a desk, counter or shelf for writing.

(h) An infirmary may be provided for residents who may need 24-hour observation on a temporary basis. Clear space of at least three feet shall be provided at each side and at the foot of each bed in the infirmary. Toilet facilities shall be provided in the infirmary.

8:36-3.15 Fire extinguisher specifications

(a) There shall be a minimun of two fire extinguishers in the basement, at least one on each floor of the building and as required in kitchen areas, all of which shall bear the seal of the Underwriters Laboratories.

(b) The following types of extinguishers shall be provided:

1. In kitchen areas, because of danger of grease fires, extinguishers shall be of the Class B dry chemical type 2-B and a minimum of five pounds. The maximum travel distance to an extinguisher shall be 50 feet.
2. In the basement area, an extinguisher shall be Class B dry chemical type 2-B and a minimum of five pounds if oil or gas is used as fuel. The maximum travel distance to an extinguisher shall be 50 feet.
3. In all other areas a Class A air-pressurized 2½ gallon water type 2-A extinguisher shall be provided. The maximum travel distance to an extinguisher shall be 75 feet.

8:36-3.16 Sound devices

If self-locking doors are used at the main entrance and other entrances which open onto a roof or balconies, they shall be equipped with a sounding device, such as a bell, buzzer or chime, which is in operating condition. The sounding device shall be affixed to the outside of the door or to the adjacent exterior wall for use in the event that a person is unable to enter the building and shall ring at an area staffed 24 hours a day.

8:36-3.17 Telecommunications

Each residential unit shall be pre-wired for telephone and television reception.

SUBCHAPTER 4. GENERAL REQUIREMENTS

8:36-4.1 Types of services provided to residents

(a) The assisted living residence or comprehensive personal care home shall provide and/or coordinate personal care and services to residents, based on assessment by qualified persons, in accordance with the New Jersey Nursing Practice Act, the rules in this manual, and the individual needs of each resident.

(b) The assisted living residence or comprehensive personal care home shall be capable of providing at least the following services: assistance with personal care, nursing, pharmacy, dining, activities, recreational, and social work services to meet the individual needs of each resident.

(c) The assisted living residence or comprehensive personal care home shall provide supervision of and assistance with self-administration of medications, and administration of medications by trained and supervised personnel, as needed by residents.

(d) The assisted living residence or comprehensive personal care home shall be capable of providing nursing services to maintain residents, including residents who require formal long-term care. However, the resident may be, but is not required to be, moved from the facility if it is documented in the health care plan that a higher level of care is required as demonstrated by one or more of the following characteristics:

1. The resident requires 24 hour, seven day a week nursing supervision.
2. The resident is bedridden for more than 14 consecutive days.
3. The resident is consistently and totally dependent in four or more of the following activities of daily living: eating, bathing, dressing, grooming, and toileting.
4. The resident has a cognitive decline severe enough to prevent the making of simple decisions regarding activities such as bathing, dressing and eating and cannot respond appropriately to cuing and simple directions.
5. The resident requires treatment of a stage three or four pressure sore or multiple stage two pressure sores. However, a resident who requires treatment of a single stage two pressure sore shall be retained and a plan of care developed and implemented to stabilize the sore and the condition which caused it.
6. The resident requires more than assistance with transfer as defined at N.J.A.C. 8:36-1.3.
7. The resident is a danger to self or others and is not controllable by medication.

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8. The resident has a medically unstable condition, has special health problems, and a regimen of therapy cannot be appropriately developed and implemented in the assisted living environment.

(e) The facility's admission agreement with each resident must clearly specify if the facility will or will not retain residents with one or more characteristics described in (d)1 through 8 above, to what extent, and, if applicable, at what additional cost.

(f) Residents who require specialized long-term care, as defined at N.J.A.C. 8:36-1.3, may not remain in the assisted living residence or assisted living program and shall be transferred to a long-term care facility that provides the applicable form of specialized care.

(g) The assisted living residence or comprehensive personal care home shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements.

8:36-4.2 Ownership

(a) The ownership of the facility and the property on which it is located shall be disclosed to the Department. Any proposed change in ownership shall be reported to the Director of the Licensing and Certification Program of the Department in writing and in conformance with licensing requirements.

(b) No facility shall be owned or operated by any person convicted of a crime relating adversely to the person's capability of owning or operating the facility.

(c) The owner or governing authority of the facility shall assume legal responsibility for the management, operation, and financial viability of the facility.

8:36-4.3 Submission and availability of documents

The facility shall, upon request, submit in writing any documents which are required by the rules in this chapter to the Director of the Licensing and Certification Program of the Department. Additionally, upon request of the Department, the facility shall submit in writing data related to utilization, demographics, costs, charges, staffing, and other planning and financial data necessary to evaluate the services provided.

8:36-4.4 Personnel

(a) The facility shall develop written job descriptions and ensure that personnel are assigned duties based upon their education, training, and competencies and in accordance with their job descriptions.

(b) All personnel who require licensure, certification, or authorization to provide resident care shall be licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey.

8:36-4.5 Staffing requirements

(a) The facility shall maintain and implement written staffing schedules. Actual hours worked by each employee shall be documented.

(b) The facility shall provide on the premises at all times the following minimum numbers of employees:

1. At least one awake personal care assistant; and
2. At least one additional employee.

(c) The facility shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel providing personal care or health services shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following:

1. The provision of services and assistance in accordance with the concepts of assisted living;
2. Emergency plans and procedures; and
3. The infection prevention and control program.

(d) The staffing ratios of this chapter are minimum only and the assisted living residence and comprehensive personal care home shall employ staff in sufficient number and with sufficient ability and training to provide the basic care and resident assistance and supervision required, based on assessment of the acuity of resident's needs.

(e) Personnel, including staff under contract, with a reportable communicable disease or infection shall be excluded from the assisted living residence and comprehensive personal care home until examined by a physician who shall certify to the administrator that the condition will not endanger the health of residents or other employees.

(f) The facility shall exercise good faith and due diligence to ensure that staff providing personal care and services to residents have not been convicted of a crime relating adversely to the person's ability to provide resident care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility.

8:36-4.6 Policy and procedure manual

(a) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following:

1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility;
2. A description of the services which the assisted living residence or comprehensive personal care home is capable of providing;
3. Policies and procedures for maintaining security;
4. Policies and procedures for reporting all diagnosed and/or suspected cases of resident abuse or exploitation. If the resident is 60 years of age or older, the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly shall be notified, in compliance with N.J.S.A. 52:27G-7.1 et seq.;
5. Policies and procedures for maintaining confidentiality of resident records, including policies and procedures for examination of resident records by the resident and other authorized persons and for release of the resident's records to any individual outside the facility, as consented to by the resident or as required by law or third party payor;
6. Policies and procedures for the maintenance of personnel records for each employee, including at least his or her name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, prior criminal records, records of physical examinations, job description, records of orientation and inservice education, and evaluations of job performance; and
7. Policies and procedures, including content and frequency, for physical examinations and immunizations and tuberculin testing upon employment and subsequently for employees and persons providing direct resident care services in the facility through contractual arrangements or written agreement.

(b) The facility shall make all policy and procedure manuals available to residents, guardians, designated responsible persons, prospective applicants, and referring agencies during normal business hours or by prior arrangement.

8:36-4.7 Resident transportation

(a) The facility shall be capable of providing resident transportation, either directly or by arrangement, to and from health care services provided outside the facility, and shall promote reasonable plans for security and accountability for the resident and his or her personal possessions, as well as transfer of resident information to and from the provider of the service, as required by individual residents and specified in resident's service plans.

(b) The facility shall assist residents, if needed, in arranging for transportation to activities of social, religious, and community groups in which the resident chooses to participate.

8:36-4.8 Written agreements

The facility shall have a written agreement or its equivalent, or a linkage for services not provided directly by the facility. If the facility provides care to residents with psychiatric disorders, the facility shall also have a written agreement with one or more com-

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munity mental health centers specifying which services will be provided by the mental health center. The written agreements shall require that services be provided in accordance with the rules in this chapter.

8:36-4.9 Reportable events

(a) The facility shall notify the Department immediately by telephone at 609-588-7725 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following:

1. Interruption for three or more hours of basic physical plant services, such as heat, light, power, water, food, or staff;
2. Termination of employment of the administrator, and the name and qualifications of his or her replacement;
3. Occurrence of epidemic disease in the facility;
4. All fires, all disasters, all residents who are missing for 24 hours, and all deaths resulting from accidents or incidents in the facility or related to facility services. The written confirmation shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages;
5. Any major occurrence or incident of an unusual nature shall be reported immediately to the Department by telephone, and shall be confirmed in writing to the Department as soon as possible thereafter;
6. All alleged or suspected crimes which are serious crimes committed by or against residents, which have also been reported at the time of occurrence to the local police department; and
7. All suspected cases of resident abuse or exploitation which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly.

8:36-4.10 Notices

(a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public:

1. All waivers granted by the Department;
2. A copy of the last annual licensure inspection survey report and the list of deficiencies from any valid complaint investigation during the past 12 months;
3. Policies and procedures regarding resident rights;
4. Business hours of the facility;
5. Policies and procedures for maintaining security of the assisted living residence and comprehensive personal care home;
6. The toll-free hot line number of the Department; telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman; and
7. The names of, and a means to formally contact, the owner and/or members of the governing authority.

8:36-4.11 Maintenance of records

(a) The facility shall maintain an annual chronological listing of residents admitted and discharged, including the destination of residents who are discharged.

(b) Statistical data, such as resident census and facility characteristics, shall be forwarded on request, in a format provided by the Department.

8:36-4.12 Admission and retention of residents

(a) The administrator of the assisted living residence or the administrator's designee shall conduct an interview with the resident and, if available, the resident's family, guardian, or interested agency, prior to or at the time of the resident's admission. The interview shall include at least orientation to the facility's policies, business hours, fee schedule, services provided, resident rights, and criteria for admission and discharge. Documentation of the resident interview shall be included in the resident's record.

(b) At the initial interview prior to, or at the time of, admission of each resident, the administrator or the administrator's designee shall be provided with the name, address, and telephone number of a family member, guardian, responsible person or designated community agency who can be notified in the event of the resident's illness, incident, or other emergency.

(c) If a facility has reason to believe, based on a resident's behavior, that the resident poses a danger to himself or herself or others, and that the facility is not capable of providing proper care to the resident, then the attending physician or the physician on call, in consultation with facility staff and a resident representative, shall determine whether the resident is appropriately placed in that facility. The facility or resident representative shall attempt to locate a new placement if necessary, and to initiate the mental health screening process in accordance with N.J.S.A. 30.

(d) If an applicant, after applying in writing, is denied admission to the assisted living residence or program, the applicant and/or his or her family, guardian, or designated community agency shall, upon written request, be given the reason for such denial in writing, signed by the administrator, within 15 days of the receipt of the written request.

(e) If there is an infirmary in the facility, residents shall be transferred to the infirmary only if they have consented to such transfer and shall remain in the infirmary for a limited time only, generally not to exceed one week.

8:36-4.13 Involuntary discharge

(a) Written notification by the administrator shall be provided to a resident and/or his or her family, guardian, or designated responsible person, of a decision to involuntarily discharge the resident from the facility. Such involuntary discharge shall only be upon grounds contained in the facility's policies and procedures and shall occur only if the resident has been notified and informed of such policies in advance. The notice of discharge shall be given at least 30 days in advance and shall include the reason for discharge and the resident's right to appeal. This 30 day advance notice shall not apply if the discharge is for reasons in accordance with the criteria specified at N.J.A.C. 8:36-4.1(d)1 through 8. A copy of the notice shall be entered in the resident's record.

(b) The resident shall have the right to appeal to the administrator any involuntary discharge from the facility. The appeal shall be in writing and a copy shall be included in the resident's record with the disposition or resolution of the appeal. The resident shall have the right to retain legal counsel to appeal.

(c) In an emergency situation, as stated in N.J.A.C. 8:36-4.12(d), for the protection of the life and safety of the resident or others, the facility may transfer the resident without 30 days notice. The Department shall be notified in the event of such discharge.

8:36-4.14 Notification requirements

(a) The resident's family, guardian, and/or designated responsible person or community agency shall be notified, immediately after the occurrence, in the event of the following:

1. The resident acquires any acute illness requiring medical care;
2. Any serious accident, criminal act or incident occurs which involves the resident and results in serious harm or injury or results in the resident's arrest or detention. The Department of Health shall also be notified of these events;
3. The resident is transferred from the facility; or
4. The resident expires.

(b) Such notification shall be given at the time of occurrence, and then documented in the resident's record.

8:36-4.15 Interpretation services

The facility shall demonstrate the ability to provide a means to communicate with any resident admitted who is non-English-speaking and/or has a communication disability, using available community or on-site resources.

8:36-4.16 Referral and transfer agreements

Each licensed assisted living residence and comprehensive personal care home shall maintain written referral and/or transfer agreements with at least one licensed acute care hospital in New Jersey, at least one licensed State, county, or private psychiatric hospital in New Jersey, and with at least one licensed New Jersey long term care facility.

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SUBCHAPTER 5. ADMINISTRATION

8:36-5.1 Appointment of administrator

An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times.

8:36-5.2 Administrator's responsibilities

(a) The administrator or designee shall be responsible for, but not limited to, the following:

1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;

2. Planning for, and administration of, the managerial, operational, fiscal, and reporting components of the facility;

3. Ensuring that all personnel are assigned duties based upon their ability and competency to perform the job and in accordance with written job descriptions;

4. Ensuring the provision of staff orientation and staff education; and

5. Establishing and maintaining liaison relationships and communication with facility staff and services and with residents and their families.

(b) The administrator shall be qualified in accordance with N.J.A.C. 8:36-1.5.

SUBCHAPTER 6. RESIDENT CARE POLICIES

8:36-6.1 Resident care policies and procedures

(a) Written resident care policies and procedures shall be established, implemented, and reviewed at intervals specified in the policies and procedures. Each review of the policies and procedures shall be documented. Policies and procedures shall include, but not be limited to, the following:

1. Resident rights;

2. Advance directives, including but not limited to, the following:

i. The circumstances under which an inquiry will be made of individuals regarding the existence and location of an advance directive;

ii. Requirements for provision of a written statement of resident rights regarding advance directives, approved by the Commissioner or his or her designee, to residents upon admission; and

iii. Requirements for documentation in the resident record;

3. The determination of staffing levels to ensure delivery of services and assistance as needed for each resident of the facility during each 24-hour period. Services may be provided directly by staff employed by the facility or in accordance with a written contract;

4. The delivery of personal care and assistance to residents in accordance with assisted living concepts which specify that each resident will be encouraged to maintain his or her independence and personal decision making abilities;

5. The referral of residents to health care providers in accordance with individual needs and resident service plans;

6. Emergency medical and dental care of residents, including notification of the resident's family, guardian, or designated community agency, and care of residents during periods of acute illness;

7. Obtaining written informed consent for any medical procedures performed at the facility which require informed consent by law, and the circumstances under which written informed consent shall be obtained;

8. Resident instruction and health education;

9. The control of smoking in the facility in accordance with N.J.S.A. 26:3D-1 et seq.

i. Residents, staff and visitors shall be permitted to smoke only in designated smoking areas having adequate outside ventilation;

ii. Nonflammable ashtrays in sufficient numbers shall be provided in designated smoking areas;

iii. Any room designated for smoking shall meet the following ventilation requirements for acceptable indoor air quality:

(1) A ventilation system which prevents contaminated air from recirculating through the facility;

(2) The number of air changes per hour within the designated smoking room shall be equivalent to the number necessary to achieve 60 cubic feet per minute per smoker, based on occupancy of no greater than five smokers per 100 square feet; and

(3) Negatively pressurized air to prevent backstreaming of smoke into nonsmoking areas of the facility;

iv. At the facility's option, a smoke-free policy may be developed, which shall include adequate notice to all applicants prior to admission to the facility;

10. Discharge, termination by the facility, transfer, and readmission of residents, including criteria for each;

11. The care and control of pets, if the facility permits pets in the facility or on its premises; and

12. A policy to determine those circumstances where the resident's absence should be investigated.

8:36-6.2 Financial arrangements

(a) The facility shall:

1. Inform residents of any and all fees for services provided and charges for supplies routinely provided by the facility. Upon admission and at the time of any price change the resident shall also be informed of the costs of supplies which are specially ordered;

2. Maintain a written record of all financial arrangements with the resident and/or his or her family, guardian, or designated community agency with copies furnished to the resident;

3. Assess no additional charges, expenses, or other financial liabilities in excess of the daily, weekly, or monthly rate included in the admission agreement, except:

i. Upon written agreement of the resident and/or his or her family, guardian, or designated community agency, who shall be given a copy of the written approval;

ii. Upon written orders of the resident's physician, stipulating specific services not included in the admission agreement;

iii. Upon 30 days' prior written notice to the resident and/or his or her family of any change in charges, expenses, or other financial liabilities that are in addition to the agreed daily, weekly, or monthly rate; and

iv. Where there is written documentation of the resident's agreement to the purchase and cost of supplies which are purchased through the facility.

4. Provide the resident with information regarding financial assistance available from third-party payors and/or other payors and referral systems for residents' financial assistance.

5. All residents who have advanced a security deposit to a facility prior to or upon their admission shall be entitled to receive interest earnings which have accumulated on such funds or property.

i. The facility shall hold such funds or property in trust for the resident and they shall remain the property of the resident. All such funds shall be held in an interest-bearing account as established under requirements of N.J.S.A. 30:13-1 et seq.

ii. The facility may deduct an amount not to exceed one percent per annum of the amount so invested or deposited for costs of servicing and processing the accounts.

iii. The facility within 60 days of establishing an account shall notify the resident, in writing, of the name of the bank or investment company holding the funds and the account number. The facility shall thereafter provide a quarterly statement to each resident it holds security funds in trust for identifying the balance, interest earned, and any deductions for charges or expenses incurred in accordance with the terms of the contract or agreement of admission.

8:36-6.3 Personal needs allowance

(a) The administrator or his or her representative shall develop a policy and procedure for handling the monthly personal needs allowance for each resident who receives Supplemental Security Income (SSI) or General Public Assistance. The personal needs allowance shall be at least the amount specified by the New Jersey State Department of Human Services pursuant to N.J.S.A. 44:7-87(h).

(b) Every administrator to whom resident's personal funds are entrusted shall maintain written records, such as a ledger, including the date each payment was received, the amount of payment, the date of each disbursement, the amount of each disbursement, the reason for each disbursement and to whom each disbursement was

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made. The personal needs allowance shall not be commingled with any other facility operating account and shall be deposited into an interest bearing account. Each resident shall receive his or her personal needs allowance within 72 hours of the receipt of the check by the administrator.

(c) The resident shall sign to acknowledge receipt of funds, or goods or services purchased with such funds, at the time of disbursement.

SUBCHAPTER 7. RESIDENT ASSESSMENTS, RESIDENT SERVICE PLAN, HEALTH CARE PLANS AND HEALTH CARE SERVICES

8:36-7.1 Resident service plans

(a) Each resident shall be assessed by a registered professional nurse to determine if the resident needs general and/or health care services. The initial nursing assessment shall not be required if a licensed physician specifies in writing, within 60 days prior to admission, that the resident has no health care service needs and is appropriate for an assisted living residence or a comprehensive personal care home.

(b) If the assessment indicates that the resident has general service needs, a resident service plan shall be developed within seven days of the resident's admission. The resident service plan shall include, but not be limited to, the following:

1. The resident's requirements for assistance in activities of daily living (ADL), if needed, including designation of persons who will provide assistance, how the services will be provided, and frequency;
2. The resident's requirements for transportation, if needed; and
3. Requirements for assistance with recreational and other activities, if needed, as determined by the resident assessment.

(c) If the resident does not require any services, a resident service plan is not needed.

(d) If the resident assessment indicates that the resident requires health care services, a health care assessment shall be completed within 14 days of admission by a registered professional nurse using the Minimum Data Set (MDS) form (available from the Department) or an assessment instrument which has been adopted by the facility that meets the requirements of (e) below. Based on that assessment a written plan of care shall be developed. The health care plan shall include, but not be limited to the following:

1. Orders for treatment or services, medications, and diet, if needed;
2. The resident's needs and preferences for himself or herself;
3. The specific goals of treatment or services, if appropriate;
4. The time intervals at which the resident's response to treatment will be reviewed; and
5. The measures to be used to assess the effects of treatment.

(e) Each resident assessment by the registered professional nurse shall include, at a minimum, evaluation of the following:

1. Cognitive patterns;
2. Communication/hearing patterns;
3. Vision patterns;
4. Physical functioning and structural problems;
5. Continence;
6. Psychosocial well-being;
7. Mood and behavior patterns;
8. Activity pursuit patterns;
9. Disease diagnoses;
10. Health conditions;
11. Oral/nutritional status;
12. Oral/dental status;
13. Skin conditions;
14. Medication use; and
15. Special treatment and procedures.

(f) If the resident does not need a health care service, a care plan is not needed for that service.

(g) The resident shall participate and, if indicated, family members shall be invited to participate in the development of the resident service plan and health care plan, if plans are needed. Participation shall be documented in the resident's record.

8:36-7.2 Implementation of plans

The resident service plan and/or health care plan shall be reviewed and, if necessary, revised quarterly, based upon the resident's response to the care provided by each of the participating services. Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health care plan.

8:36-7.3 Health care services

(a) The assisted living residence and comprehensive personal care home shall assure that the resident receives health care services, as defined at N.J.A.C. 8:36-1.3, under the direction of a registered professional nurse, in accordance with the health care plan.

(b) The facility shall have at least one registered professional nurse available at all times. Available, in this instance, shall mean on call and capable of being reached by telephone.

(c) A registered professional nurse shall be responsible for developing nursing practice policies and procedures and the coordination of all health care services required in the resident's health care plan.

(d) Written policies and procedures shall insure, but not be limited to the following:

1. Assessment of the health service needs of all residents in the facility, and reassessment at least quarterly of all residents, including those who did not have an initial nursing service plan;
2. Monitoring of the conditions of the residents on a periodic basis;
3. Notification of the registered nurse if there are significant changes in a resident's condition;
4. Assessment of the resident's need for referral to a physician or community agencies as appropriate; and
5. Maintenance of records as required.

8:36-7.4 Provision of health care services

(a) The facility shall arrange for health care services to be provided to residents as needed, in accordance with assessments and with health care plans.

(b) At the time of admission, arrangements shall be made between the administrator and the resident, guardian, or designated community agency regarding the physician and dentist to be called in case of illness, or the person to be called for a resident who, because of religious affiliation, is opposed to medical treatment.

(c) The initial health care service assessment shall be documented by the health care professional providing the service and shall be updated as required, in accordance with professional standards of practice, at least quarterly.

(d) The health care professional shall notify the resident's physician or the physician's designee of any significant change in the resident's physical or psychological condition.

(e) The administrator or designee shall ensure that an up-to-date log is maintained containing the names of all residents who are receiving health care services, the type of health care services being provided to the resident, the names of the health care personnel who are providing the services, and the date and reasons for the resident's discontinuing of health care services.

(f) The registered professional nurse or a physician shall be called at the onset of illness of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care.

(g) Each resident shall have an annual physical examination by a physician, which shall be documented in the resident's record. The physician shall certify annually that the resident does not have needs which exceed the care which the assisted living residence or comprehensive personal care home is capable of providing.

(h) Residents shall be permitted free choice of a physician.

(i) The administrator shall arrange for a physician to be available for emergencies, including injuries or accidents to residents, or when required by a resident's condition.

(j) If it is determined that there is a medical need for a transfer to another health care facility because the assisted living residence or comprehensive personal care homes cannot meet the resident's needs such transfers shall be initiated promptly, in accordance with

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N.J.A.C. 8:36-4.1(d)1. The registered professional nurse shall be notified to ensure that the resident is receiving appropriate care during the transfer period. If the resident is not transferred within seven days, the Department shall be notified and assistance shall be requested from the Department to arrange for transfer of the resident.

8:36-7.5 Quality assurance

The facility shall develop written policies and procedures for and establish a Quality Assurance Program for all residents receiving health care services.

SUBCHAPTER 8. DINING SERVICES

8:36-8.1 Provision of meals

The assisted living residence or comprehensive personal care home shall providing dining services to meet the daily nutritional needs of residents, directly in the facility.

8:36-8.2 Designation of a food service supervisor

(a) The facility shall designate a food service supervisor who, if not a dietitian, functions with scheduled consultation from a dietitian. When meals are prepared in the facility, the food service supervisor or designee shall be present in the facility. The food service supervisor shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the dining service;

2. Participating in planning and budgeting for the dining service;

3. Ensuring that dining services are provided as specified in the dining portion of the resident service plan;

4. Assisting in developing and maintaining written job descriptions for dining service personnel, and assigning duties based upon education, training, competencies, and job descriptions; and

5. Participating in staff education activities and providing consultation to facility personnel.

8:36-8.3 Responsibilities of dietitians

(a) If indicated, according to residents' needs, a dietitian shall be responsible for providing resident care, including, but not limited to, the following:

1. Assessing the nutritional needs of the resident. If indicated, preparing the dietary portion of the health care plan on the basis of the assessment, providing dietary services to the resident as specified in the dietary portion of the health plan, reassessing the resident, and revising the dietary portion of the health care plan. Each of these activities shall be documented in the resident's record; and

2. Providing nutritional counseling and education to residents.

8:36-8.4 Requirements for dining services

(a) The facility and personnel shall comply with the provisions of Chapter XII of the New Jersey Sanitary Code, N.J.A.C. 8:24.

(b) A current diet manual shall be available to the dining service personnel and to the nursing service personnel.

(c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following:

1. At least three meals shall be prepared and served daily to residents;

2. The facility shall select foods and beverages, which include fresh and seasonal foods, and shall prepare menus with regard to the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal preference of residents;

3. Written, dated menus shall be planned at least 14 days in advance for all diets. The same menu shall not be used more than once in any continuous seven day period;

4. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus shall be posted in a conspicuous place in residents' area, and/or a copy of the menu shall be provided to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes, shall be kept on file in the facility for at least 30 days;

5. Diets served shall be consistent with the diet manual, the dietitian's instructions, and, if applicable for special diets, shall be served in accordance with physicians' orders;

6. Nutrients and calories shall be provided for each resident, based upon current recommended dining allowances of the Food and Nutrition Board of the National Academy of Sciences, National Research Council, adjusted for age, sex, weight, physical activity, and therapeutic needs of the resident, if applicable;

7. Between-meal snacks and beverages shall be available at all times for each resident, unless medically contraindicated as documented by a physician in the resident's health care plan;

8. Substitute foods and beverages of equivalent nutritional value shall be available to all residents;

9. There shall be designated staff responsible for observing meals refused or missed and documenting the name of the resident and the meal refused or missed;

10. All meals shall be served at the proper temperature and shall be attractive when served to residents. Place settings and condiments shall be appropriate to the meal;

11. Seatings shall be arranged for each meal in order to accommodate individual resident's meal-time preferences, in accordance with facility policies;

12. A record shall be maintained for each resident, identifying the resident by name, diet order, if applicable, and other information, such as meal patterns, when on a calculated diet and allergies. Such record shall be available in the dining area; and

13. If the resident is ill, or so requests, meals shall be served in his or her apartment, as indicated in the resident service plan and in accordance with facility policy.

8:36-8.5 Commercial food management services

If a commercial food management firm provides dining services, the firm shall be required to conform to the standards of this subchapter.

SUBCHAPTER 9. PHARMACEUTICAL SERVICES

8:36-9.1 Provision of pharmaceutical services

The assisted living residence and comprehensive personal care home shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with physician's orders and with each resident's health care plan.

8:36-9.2 Self-administration of medications

(a) Self-administration of medications by residents shall be performed as follows:

1. By removing a dose from a previously dispensed, properly labeled container (including a unit dose container);

2. By verifying it with the directions on the label; and

3. By taking orally, injecting, inserting, or otherwise administering the medication;

(b) If indicated in the resident's health care plan, a designated employee shall provide resident supervision and/or assistance during self-administration of medications in accordance with physicians' orders. Any employee who has been designated to provide resident supervision or assistance during self-administration of medications shall have received training from the licensed professional nurse or the licensed pharmacist, and such training shall be documented.

1. The facility shall document the provision of training to each employee who has been designated to provide resident supervision and/or assistance with self-administration of medications; and

2. The facility shall document any observed instance where medications are not taken in accordance with physician's orders.

8:36-9.3 Administration of medications

(a) All medications administered by qualified personnel shall be administered in accordance with prescriber orders, facility policy, and all Federal and State laws and regulations.

(b) The registered professional nurse may delegate responsibility, in accordance with N.J.A.C. 13:37-6.2, for medication administration to personal care assistants, based upon individual residents' needs and circumstances, within specific limits. These limits shall include, but not be limited to, the following:

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1. Administration of oral medications, external applications, rectal suppositories, and pre-dawn insulin injections only may be delegated; class two drugs (narcotics), anti-psychotic drugs, and drugs requiring any other mode of administration are excluded from the nurse's delegation;

2. A Statewide training program regarding medication administration shall be completed by each personal care assistant who will administer medications;

3. The resident's condition shall be medically stable;

4. The delegating nurse shall review with the personal care assistant medication actions and untoward effects for each drug to be administered. Pertinent information about medications' adverse effects, side effects, and potential interactions shall be incorporated into the care plan for each resident, with interventions to be implemented by the personal care assistant and other caregiving staff; and

5. An FDA approved unit dose drug distribution system shall be developed and implemented.

(c) Medications for individual residents shall only be removed from their original prescription containers by qualified personnel when an individual medication administration device is used.

(d) Each resident shall be identified prior to drug administration.

(e) Drugs prescribed for one resident shall not be administered to another resident.

(f) Personnel shall report drug errors and adverse drug reactions immediately to the director of health services, to the prescriber, and to the pharmacist, and shall document the incident in the resident's record.

8:36-9.4 Designation of a pharmacist

(a) The facility shall designate a pharmacist who shall direct pharmaceutical services and provide consultation to the physician, facility staff, and residents, as needed. The pharmacist shall assist the facility with, at a minimum, the following:

1. Training of employees;

2. Educating residents regarding medications;

3. Establishing policies and procedures which ensure safe and appropriate self-administration of medications;

4. Reviewing medication records; and

5. Inspecting all common areas that the facility has designated for storage of medications and maintaining records of such inspections.

8:36-9.5 Storage of medications

(a) For those residents who do not self-administer medications, the administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications.

1. The storage area shall be kept locked when not in use.

2. The storage area shall be used only for storage of medications and medical supplies.

3. The key to the storage area shall be kept on the person of the employee on duty who is responsible for resident supervision.

4. Each resident's medications shall be kept separated within the storage area, with the exception of large volume medications which may be labeled and stored together in the storage area.

(b) Medications shall be stored in accordance with manufacturer's instructions and with U.S.P. (United States Pharmacopoeia) regulations.

(c) Unless the facility is using an individual medication administration device, all medications shall be kept in their original containers and shall be properly labeled and identified.

1. The label of each resident's prescription medication container shall be permanently affixed and contain the resident's full name, physician's name, prescription number, name and strength of drug, lot number, date of issue, expiration date, manufacturer's name if generic, directions for use, and cautionary and/or accessory labels. If a generic substitute is used, the drug shall be labeled according to the Drug Utilization Review Council Formulary, N.J.S.A. 24:6E-1 et seq. Required information appearing on individually packaged drugs or within an alternate medication delivery system need not be repeated on the label.

2. All over-the-counter (OTC) medications repackaged by the pharmacy shall be labeled with an expiration date, name and strength of the drug, lot number, date of issue, manufacturer's name if generic, and cautionary and/or accessory labels, in accordance with U.S.P. regulations. Original manufacturer's containers shall be labeled with at least the resident's name, and the name label shall not obstruct any of the aforementioned information.

3. If a unit dose drug distribution system is used, each dose of medication shall be individually packaged in a hermetically sealed, tamper-proof container, and shall carry full manufacturer's disclosure information on each discrete dose. Disclosure information shall include, but not be limited to, the following: product name and strength, lot number, expiration date, and manufacturer's or distributor's name. ("Bingo" or punch card systems are not required to have each discrete dose labeled.)

(d) Single use and disposable items shall not be reused.

(e) No stock supply of prescription medications shall be maintained, unless prior approval is obtained from the Department.

(f) Discontinued or expired medications shall be destroyed within 30 days in the facility, or, if unopened and properly labeled, returned to the pharmacy. All medication destruction in the facility shall be witnessed and documented by two persons, each of whom shall be either the administrator, the licensed nurse or the consultant pharmacist.

SUBCHAPTER 10. RESIDENT ACTIVITIES

8:36-10.1 Provision of resident activities

(a) A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, on-site or off-site, to meet the individual needs of residents.

(b) Residents shall have the opportunity to organize and participate in a Resident Council that presents the resident's concerns to the administrator of the facility.

SUBCHAPTER 11. SOCIAL WORK SERVICES

8:36-11.1 Provision of social work services

The facility shall arrange for the provision of clinical social work services to residents who require them, in accordance with N.J.S.A. 45:15BB.

SUBCHAPTER 12. EMERGENCY SERVICES AND PROCEDURES

8:36-12.1 Emergency medical services

(a) Emergency medical services shall be available to or arranged for residents requiring these services.

(b) The facility shall develop a written plan for arranging for emergency transportation of residents for medical care and returning them to the assisted living residence.

8:36-12.2 Emergency plans and procedures

(a) The facility shall develop written emergency plans, policies, and procedures which shall include plans and procedures to be followed in case of medical emergencies, power failures, fire, or natural disasters. The emergency plans shall be filed with the Department of Health and the Department shall be notified when the plans are changed. Copies of emergency plans shall also be forwarded to other agencies in accordance with State and municipal laws.

(b) The emergency plans, including a written evacuation diagram specific to the unit that includes evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers, and all emergency procedures, shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and resident evacuation as part of their initial orientation and at least annually thereafter. All residents shall be instructed in emergency evacuation procedures.

(c) Procedures for emergencies shall specify persons to be notified, process of notification and verification of notification, locations of emergency equipment and alarm signals, evacuation routes, procedures for evacuating residents, procedures for reentry and

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recovery, frequency of fire drills, tasks and responsibilities assigned to all personnel, and shall specify medications and records to be taken from the facility upon evacuation and to be returned following the emergency.

8:36-12.3 Drills and tests

(a) The facility shall conduct at least one drill of the emergency plans every month, of which at least one annually shall take place during every working shift. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills.

(b) At least one joint fire drill shall be conducted annually, involving the local fire department. The facility shall notify first aid and civil defense agencies of this drill and shall participate in community-wide disaster drills.

(c) The facility shall test at least one manual pull alarm each month of the year and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

(d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable National Fire Protection Association (NFPA) requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance.

SUBCHAPTER 13. RESIDENT RECORDS

8:36-13.1 Health record

A current, complete health record shall be maintained for each resident who is receiving health care services.

8:36-13.2 Confidentiality

Records and information regarding the individual resident shall be considered confidential and the resident shall have the opportunity to examine such records, in accordance with facility policies. The written consent of the resident shall be obtained for release of his or her records to any individual outside the facility, except in the case of the resident's transfer to another health care facility, or as required by law, third-party payor, or authorized government agencies.

8:36-13.3 Record retention

All records shall be maintained for a period of 10 years after the discharge of a resident from the assisted living facility.

8:36-13.4 Record availability

The records required in this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department of Health.

8:36-13.5 Register

(a) A register which contains a current census of all residents along with other pertinent information, shall be maintained by each assisted living residence. The following standards for maintaining the register shall apply:

1. The administrator or the administrator's designee shall make all entries in the register and shall be responsible for its maintenance and safe-keeping;

2. The register shall be kept up-to-date at all times. Admissions, discharges and discharge destination, and other changes shall be recorded within 48 hours;

3. The register, which is a permanent record, shall be kept in a safe place; and

4. All entries into the register shall be clear, legible, and written in ink or typed.

8:36-13.6 Residents' individual records

(a) Each resident's record shall include at least the following:

1. The resident's completed admission application and all records forwarded to the facility;

2. The resident's name, last address, date of birth, name and address of sponsor or interested agency, date of admission, date of discharge (and discharge destination) or death, the name, address and telephone number of physician to be called, and the name and address of nearest relative, guardian, responsible person, or interested agency, together with any other information the resident wishes to have recorded;

3. A copy of the resident's service plan and/or health care plan, if applicable;

4. A complete record of physicians' visits, if applicable, including dates and physician's comments; and

5. All assessments and treatments by health care and service providers, entered at least annually. Documentation and/or notes from all health care and service providers shall be entered at least quarterly, or more frequently based on individual resident's needs.

8:36-13.7 Record of death

Whenever a resident dies in the assisted living residence, the administrator or the administrator's designee shall include written documentation from the physician of the date and time of death, the name of the person who pronounced the death, disposition of the body, and a record of notification of the family.

SUBCHAPTER 14. RESIDENT RIGHTS

8:36-14.1 Posting and distribution of statement of resident rights

(a) To assure the highest quality of services, each Assisted Living provider will post and distribute a statement of resident rights, as approved and issued by the Department in accordance with N.J.S.A. 30:13, the Nursing Home Patients Bill of Rights, and consistent with the following principles of assisted living:

1. Provide personalized services and care to meet each resident's needs;

2. Foster the independence and individuality of each resident;

3. Treat each resident with respect, courtesy, consideration and dignity;

4. Assure each resident the right to make choices with respect to services and lifestyle;

5. Assure each resident's right to privacy;

6. Nurture the spirit and uniqueness of each resident;

7. Encourage families and friends participation in resident service planning and implementation; and

8. Provide opportunities for the Assisted Living Facilities to become a valuable community resource.

SUBCHAPTER 15. HOUSEKEEPING, SANITATION, SAFETY AND MAINTENANCE

8:36-15.1 Provision of services

(a) The facility shall provide and maintain a sanitary and safe environment for residents, in accordance with Chapter 12, New Jersey Sanitary Code, N.J.A.C. 8:24.

(b) The facility shall provide housekeeping, laundry, pest control, and maintenance services, and shall provide assistance to residents who require assistance with these services in their residential units.

(c) Written objectives, policies, a procedure manual, and an organizational plan for housekeeping, sanitation, safety, laundry and maintenance services shall be developed and implemented.

8:36-15.2 Housekeeping

(a) A written work plan for housekeeping operations shall be established and implemented, with categorization of cleaning assignments as daily, weekly, monthly, or annually within each area of the facility. The facility shall have a written schedule that determines the frequency of cleaning and maintenance of all equipment, structures, areas, and systems.

(b) Housekeeping personnel shall be trained in cleaning procedures, including the use and care of equipment.

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8:36-15.3 Resident environment

(a) The following housekeeping and sanitation conditions shall be met:

1. The facility and its contents, including all surfaces such as tables, floors, walls, beds and dressers, shall be clean to sight and touch and free of dirt and debris;

2. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors;

3. All resident areas shall be free of noxious odors;

4. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Items which are broken or worn to the extent that they may cause discomfort or present danger to residents shall be repaired, replaced, or removed promptly;

5. All equipment and materials necessary for cleaning, disinfecting, sanitizing, and sterilizing (if applicable) shall be provided;

6. For central kitchens, thermometers which are accurate to within three degrees Fahrenheit shall be kept in a visible location within refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration. Temperatures shall be maintained in accordance with Chapter 12 of the New Jersey Sanitary Code, N.J.A.C. 8:24;

7. Lighted and ventilated storage spaces shall be provided in the facility for the proper storage of residents' clothing, linens, drugs, food, cleaning and other supplies;

8. Articles in storage shall be elevated from the floor and away from walls (if moisture is present), ceilings, and air vents;

9. Unobstructed aisles shall be provided in storage areas;

10. Effective and safe controls shall be used to minimize and eliminate the presence of rodents, flies, roaches and other vermin in the facility;

11. When facility housekeeping services are provided, items such as bedpans, toilets and sinks shall be disinfected, using a process for disinfection established by the facility; and

12. Toilet tissue, soap, paper towels or air dryers, and waste receptacles shall be provided in each common area toilet facility at all times. A self-draining dish or device shall be provided for storage of bar soap, if bar soap is used. Resident's personal cloth towels may be used in residential units.

(b) The following safety conditions shall be met:

1. Non-carpeted floors in public areas shall be coated with slip-resistant floor finish, and any carpeting in public areas shall be kept clean and odor free and shall not be frayed, worn, torn, or buckled;

2. All equipment shall have unobstructed space provided for operation;

3. Pesticides shall be applied in accordance with N.J.A.C. 7:30;

4. All household and cleaning products used by facility staff shall be identified, labeled, and secured. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room. The telephone number of the poison control center shall be conspicuously posted in the facility;

5. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater;

6. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in accordance with fire safety requirements specified at Table 313.1.4.1 of BOCA National Building Code;

7. If pets are allowed in the facility, the facility shall provide safeguards to prevent interference in the lives of residents, and the facility should comply with guidelines for pet facilitated therapy issued by the New Jersey State Department of Health;

8. A licensed electrician or an independent inspection agency approved by the State of New Jersey shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition;

i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are U.L. approved; and

ii. The written statement shall be forwarded annually to the New Jersey Department of Health, Division of Health Facilities Evaluation.

8:36-15.4 Waste removal

(a) All solid or liquid waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey State Department of Environmental Protection and the New Jersey State Department of Health. Solid waste which is stored within the building shall be stored in insectproof, rodentproof, fireproof, nonabsorbent, watertight containers with tightfitting covers and collected from storage areas regularly so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24.

(b) If garbage compactors are used, they shall comply with all State and local codes.

8:36-15.5 Heating and air conditioning

(a) The heating and air conditioning system shall be adequate to maintain the required temperature in all areas used by residents. Residents may have individually controlled thermostats in residential units in order to maintain temperatures at their own comfort level.

1. During the heating season, the temperature in the facility shall be kept at a minimum of 72 degrees Fahrenheit (22 degrees Celsius) during the day ("day" means the time between sunrise and sunset) and 68 degrees Fahrenheit (20 degrees Celsius) at night, when residents are in the facility.

2. The facility or residents may not utilize portable heaters.

3. During warm weather conditions, the temperature within the facility shall not exceed 82 degrees Fahrenheit, in accordance with Chapter 173, Laws of New Jersey, 1989.

i. The facility shall provide for and operate adequate ventilation in all areas used by residents.

ii. All areas of the facility used by residents shall be equipped with air conditioning and the air conditioning shall be operated so that the temperature in these areas does not exceed 82 degrees Fahrenheit.

4. Residents may regulate temperature controls in residential units, and may, by choice, exceed 82 degrees Fahrenheit.

(b) Filters for heaters and air conditioners shall be provided as needed and shall be maintained in accordance with manufacturer's specifications.

8:36-15.6 Water supply

(a) The water supply used for drinking or culinary purposes shall be adequate in quantity, of a safe and sanitary quality, and from a water system which shall be constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act, N.J.S.A. 58:12A-1 et seq., N.J.A.C. 7:10 et seq. and local laws, ordinances, and regulations. Copies of the Safe Drinking Water Act can be obtained from the Department of Environmental Protection, Bureau of Potable Water, CN 209, Trenton, New Jersey 08625.

(b) The temperature of the hot water used for bathing and handwashing shall be at least 95 degrees and shall not exceed 110 degrees Fahrenheit (35-43 degrees Celsius).

(c) Equipment requiring drainage, such as ice machines, shall be drained to a sanitary connection, in accordance with State and local codes.

(d) The sewage disposal system shall be maintained in good repair and operated in compliance with State and local laws, rules, and ordinances.

8:36-15.7 Building and grounds maintenance

The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.

8:36-15.8 Laundry services

(a) Written policies and procedures shall be established and implemented for the facility's laundry services, including, but not limited to, policies and procedures regarding the following:

1. Storage and transportation of laundry;

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2. Collection and storage of soiled laundry in a ventilated area;
3. Protection of clean laundry from contamination during processing, transporting, and storage; and
4. Handling and laundering of resident's clothing and personal items separately from other laundry.

(b) Soiled laundry shall be stored in a ventilated, vermin-proof area, separate from other supplies, and shall be stored, sorted, rinsed, and laundered only in areas specifically designated for those purposes.

(c) All soiled laundry from resident rooms and other service areas shall be stored, transported, collected, and delivered in a covered laundry bag or cart. Laundry carts shall be in good repair, kept clean, and identified for use with either clean or soiled laundry.

(d) Clean laundry shall be protected from contamination during processing, storage, and transportation within the facility.

(e) Soiled and clean laundry shall be kept separate. An established procedure shall be followed to reduce the number of bacteria in the fabrics. Equipment surfaces that come into contact with laundry shall be sanitized.

(f) Residents who choose to launder their personal items shall be provided with in-house assistance in accordance with facility policy.

(g) If the facility provides a laundry service on site in lieu of using a commercial laundry service, it shall provide a receiving, holding, and sorting area with hand-washing facilities. The walls, floors, and ceilings of the area shall be clean and in good repair. The flow of ventilating air shall be from clean to soiled areas, and ventilation shall be adequate to prevent heat and odor build-up.

SUBCHAPTER 16. INFECTION PREVENTION AND CONTROL SERVICES

8:36-16.1 Infection control program

(a) The facility shall develop and implement an infection prevention and control program.

(b) The licensed professional nurse, in coordination with the administrator, shall be responsible for the direction, provision, and quality of infection prevention and control services. The health care services director, in coordination with the administrator, shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, and an organizational plan for the infection prevention and control service.

8:36-16.2 Development of infection control policies and procedures

(a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications:

1. Guideline for Handwashing and Hospital Environmental Control; and
2. Enforcement Procedures for Occupational Exposure to Hepatitis B Virus (HVB) and Human Immunodeficiency Virus (HIV), OSHA Instruction CPL 2-2.44A, August 15, 1988 (or current edition).

NOTE: Centers for Disease Control publications can be obtained from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
or
Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

8:36-16.3 General infection control policies and procedures

(a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following:

1. In accordance with Chapter II, New Jersey State Sanitary Code, N.J.A.C. 8:57, a system for investigating, reporting, and evaluating the occurrence of all infections or diseases which are reportable or conditions which may be related to activities and procedures of the facility, and maintaining records for all residents or personnel having these infections, diseases, or conditions;
2. Infection control and isolation, in accordance with the Centers for Disease Control and Occupational Safety and Health Administration publication, "Enforcement Procedures for Occupational Exposure to Hepatitis B Virus (HVB) and Human Immunodeficiency Virus (HIV)," OSHA Instruction CPL 2-2.44A, August 15, 1988 (or current edition);
3. Exclusion from work, and authorization to return to work, for personnel with communicable diseases;
4. Surveillance techniques to minimize sources and transmission of infection;
5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident;
6. Protocols for identification of residents with communicable diseases and education of residents regarding prevention and spread of communicable diseases;
7. Sterilization, disinfection, and cleaning practices and techniques used in the facility, including, but not limited to, the following:
   i. Care of utensils, instruments, solutions, dressings, articles, and surfaces;
   ii. Selection, storage, use, and disposition of disposable and non-disposable resident care items. Disposable items shall not be reused;
   iii. Methods to ensure that sterilized materials are packaged, labeled, processed, transported, and stored to maintain sterility and to permit identification of expiration dates; and
   iv. Care of urinary catheters, intravenous catheters, respiratory therapy equipment, and other devices and equipment that provide a portal of entry for pathogenic microorganisms; and
8. Needles and syringes used by residents as part of home self-care shall be destroyed in accordance with N.J.S.A. 2A:170-25.17, and amendments thereto, and shall then be placed in a puncture-resistive container prior to disposal.

8:36-16.4 Employee health and resident policies and procedures for infection prevention and control

(a) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last six months, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:

1. If the Mantoux test is significant (10 millimeters or more of induration), a chest x-ray shall be performed and, if necessary, followed by chemoprophylaxis or therapy.
2. Any employee with positive results shall be referred to the employee's personal physician and shall be excluded from work until the physician provides written approval to return.

(b) The facility shall have written policies and procedures establishing timeframes, requiring annual Mantoux tuberculin skin tests for all employees except those exempted under (a) above.

(c) The facility shall assure that all current employees who have not received the Mantoux test upon employment, except those exempted by (a) above, shall receive a test within 3 months of the effective date of this rule. The facility shall act on the results of tests of current employees in the same manner as prescribed in (a) above.

(d) Employees who have signs or symptoms of a communicable disease shall not be permitted to perform functions that expose residents to risk of transmission of the disease.

(e) If a communicable disease prevents the employee from working for a period of more than three days, a physician's statement approving the employee's return shall be required prior to the employee's return to work.

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(f) The facility shall develop and implement procedures for the care of employees who become ill while at work or who have a work-related accident.

(g) The facility shall maintain listings of all residents and personnel who have reportable infections, diseases, or conditions.

(h) High-level disinfection techniques approved by the New Jersey State Department of Health shall be used for all reusable respiratory therapy equipment and instruments that touch mucous membranes.

(i) Disinfection procedures for items that come in contact with bed pans, sinks, and toilets shall conform with established protocols for cleaning and disinfection.

(j) All residents shall be provided with an opportunity to wash their hands before each meal and shall be encouraged to do so. Staff shall wash their hands before each meal and before assisting residents in eating.

(k) Personnel who have had contact with resident excretions, secretions, or blood, whether directly or indirectly, in activities such as performing a physical examination, providing catheter care, and emptying bedpans, shall wash their hands with soap and warm water for between 10 and 30 seconds or use other effective hand sanitation techniques immediately after such contact.

(l) Equipment and supplies used for sterilization, disinfection, and decontamination purposes shall be maintained according to manufacturers' specifications.

(m) The facility shall maintain records documenting contagious diseases contracted by employees during employment, as specified at N.J.A.C. 8:57-1.3(a) and (b).

8:36-16.5 Staff education and training for infection prevention and control

All staff members shall be informed about the facility's infection control procedures, including personal hygiene requirements.

8:36-16.6 Regulated medical waste

(a) The facility shall develop policies and procedures for the collection, storage, and handling of regulated medical waste.

(b) The facility shall comply with the provisions of N.J.S.A. 13:1E-48.1 et seq., the Comprehensive Regulated Medical Waste Management Act, and all rules and regulations promulgated pursuant to the aforementioned Acts.

SUBCHAPTER 17. COMPREHENSIVE PERSONAL CARE HOMES

8:36-17.1 Eligibility

(a) Eligibility for conversion to a comprehensive personal care home shall be open exclusively to the following:

1. Freestanding residential health care facilities which were licensed or Certificate of Need-approved on or before the date these rules become effective;

2. Residential health care beds located within a long-term care facility that was licensed or Certificate of Need-approved on or before January 1, 1993;

3. Licensed long-term care beds;

4. "Class C" boarding homes which were licensed on or before January 1, 1993. In order to be eligible for conversion to a comprehensive personal care home, a "Class C" boarding home must, at a minimum, be capable of meeting the physical plant standards for licensure as a comprehensive personal care home in N.J.A.C. 8:36-17.3.

(b) Hospice programs which have been Medicare-certified for at least 12 consecutive months are also eligible for licensure as a comprehensive personal care home. These programs may propose the construction of a new comprehensive personal care home. Such new construction shall, at a minimum, meet the physical plant requirements specified at N.J.A.C. 8:36-17.3.

8:36-17.2 Services provided to residents

Each comprehensive personal care home shall comply with the following subchapters and sections of N.J.A.C. 8:36:1, 2, 3.8(c), 3.15, 3.16, and 4-16, (except 15.5(a)4).

8:36-17.3 Physical plant

(a) Each comprehensive personal care home shall, at a minimum:

1. Maintain substantial compliance with the 1977 Uniform Construction Code;

2. Maintain a comprehensive automatic fire-suppression system throughout the facility;

3. Maintain compliance with N.J.A.C. 5:23-7.

4. Provide smoke detectors in all resident bedrooms, living rooms, and public areas; and

5. Provide corridor widths of at least 36 inches of clear space.

(b) Ventilation requirements for comprehensive personal care homes are as follows:

1. Means of ventilation shall be provided either by a window with an openable area or by mechanical ventilation for every habitable room. If mechanical ventilation is used, there shall be at least two air changes per hour.

2. Means of ventilation shall be provided for every bathroom or water closet compartment (toilet). Ventilation shall be provided either by a window with an openable area or by mechanical ventilation with at least 10 air changes per hour.

3. All hallway corridors and passageways shall have a minimum of two outside air changes per hour.

(c) The interior finish of a comprehensive personal care home shall comply with the following:

1. Interior wall and ceiling finishes in resident areas shall be Class B (having a flame spread of 26-75 and smoke development of 0-450, based on test results from National Fire Protection Association (NFPA) 255, Standard Method of Test of Surface Burning Characteristics of Building Materials). In all other areas, interior wall and ceiling finishes shall be Class B or Class C (having a flame spread of 76-200 and smoke development of 0-450).

2. Interior floor finishes in corridors, stairways and exits shall be Class I or Class II (critical radiant flux, minimum of 0.45 watts per square centimeter (w/sq. cm.) or 0.22 w/sq. cm., respectively, based on test results from NFPA 253, Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source).

(d) Residential units occupied by one person shall have a minimum of 80 square feet of clear floor area. ("Clear floor area" means space exclusive of vestibule, closets, bathroom and, if provided, kitchenette.)

(e) In units occupied by more than one resident, there shall be a minimum of 50 additional square feet of clear floor area.

(f) No residential unit in a comprehensive personal care home may be occupied by more than two individuals. An exception may be considered in those instances where an eligible facility at the time of conversion to a comprehensive personal care home has more than two individuals in a unit. However, as attrition occurs, the number of individuals per residential unit shall be reduced to no more than two.

8:36-17.4 Information provided to residents

Each comprehensive personal care home administrator, manager, or their designee shall explain to all residents assisted living concepts, services to be provided based on these concepts, and shall explain all charges for these services.

8:36-17.5 Prohibition of resident discharge on conversion of facility

An eligible existing facility converting to a comprehensive personal care home shall not discharge any current resident solely because of the conversion. If compliance with this rule results in more than two individuals per residential unit, the facility shall apply for the exception noted at N.J.A.C. 8:36-17.3(f).

8:36-17.6 Combination of license categories

Another licensed bed category may be located within a distinct and separate section of the comprehensive personal care home. The comprehensive personal care home shall comply fully with all licensure requirements applicable to each licensed component.

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# (a)

## DIVISION OF EPIDEMIOLOGY, ENVIRONMENTAL AND OCCUPATIONAL HEALTH SERVICES

## Chapter IV of State Sanitary Code
## Operation of Clinical Laboratories; Reporting by Laboratory Supervisors
## Proposed Amendment: N.J.A.C. 8:44-2.11

Authorized By: Public Health Council, William Frascella, Jr., O.D., Chairperson.
Authority: N.J.S.A. 26:1A-7.
Proposal Number: PRN 1993-441.

A **public hearing** concerning this proposal will be held at 1:00 P.M. on:

Monday, September 13, 1993
Department of Health
Room 106 (Auditorium)
Health-Agriculture Building
John Fitch Plaza
Trenton, New Jersey 08625

Submit written comments by September 15, 1993 to:
Martha Stanbury, Manager
Surveillance Program
Occupational Health Service, Room 701
New Jersey Department of Health
CN 360
Trenton, New Jersey 08625-0360

The agency proposal follows:

### Summary

The Department of Health proposes to amend N.J.A.C. 8:44-2.11 to require clinical laboratories to report to the State Department of Health certain data in addition to already-required elevated blood and urine test results of the following hazardous heavy metals: lead, arsenic, mercury and cadmium. Additional reportable data include: name and address of the patient, name and address of his or her physician, name and address of the patient's employer (if test was ordered because of occupational exposure), and other related information. The Department also proposes to lower the reportable level for cadmium in urine from 10 micrograms per liter (10 ug/L) to three micrograms per gram of creatinine (three ug/gm creatinine) to meet criteria for cadmium biological monitoring in a new health standard for cadmium from the Occupational Safety and Health Administration (OSHA), U.S. Department of Labor.

Each of these four heavy metals is a recognized occupational and environmental hazard, potentially causing toxicity and chronic disease in body organs, including kidneys, lungs, bone, stomach and brain. Occupational and environmental diseases are significant threats to the public's health in New Jersey. There are many known hazardous occupations and waste disposal sites which may cause harmful exposures to workers and members of the public. By requiring the reporting of elevated levels of heavy metals in blood and/or urine to include relevant demographic and related data, the Department will have necessary and sufficient information to be able to investigate the causes of occupational and environmental diseases and prevent additional such disease from occurring. To date, most laboratories have been willing to provide sufficient additional data voluntarily to the Department to conduct public health follow-up to these heavy metals reports. By requiring rather than requesting these data from the laboratories, laboratories can require those who order the tests to supply the information routinely, and, in turn, the Department of Health can obtain the information more efficiently and completely.

### Social Impact

Occupational and environmental diseases and injuries are continually occurring to persons exposed to hazardous substances in the workplace and the environment. Pain and suffering and increased medical costs are incurred by those who suffer from such diseases. Knowledge of the extent of occupational and environmental diseases will enable the Department of Health to investigate and ascertain the causes of these disease and take steps to prevent future hazardous substance exposure and future illness and injury to present workers and members of the public.

Since the implementation of the rules in 1985, the State Department of Health has received over 20,000 heavy metals laboratory reports. This information has allowed the Department to initiate: one, industrial hygiene investigations to evaluate existing controls and to provide recommendations for improving controls; two, referrals to other governmental agencies, such as local health departments, OSHA, or OSHA Consultative Services in the New Jersey State Department of Labor; three, epidemiologic investigations of populations of workers exposed to toxic substances, and four, education programs targeted at the worker, the employer, and the medical provider.

By requiring the reporting of necessary and sufficient information on the source of heavy metals exposure and the affected individual, better data with which to target prevention and control activities will be available. All laboratories in New Jersey are covered under this amended rule.

The social conditions on which the proposed amendments to this rule are based include the increased concern by the public about environmental hazards, many of which emanate from worksites. There is increased need to identify the specific locations of these hazards and to take actions to reduce occupational and environmental exposures to them. Reporting of individuals already injured from these exposures provides information that leads back to the sources of exposure and thus initiates appropriate public health actions.

These amendments will impact primarily on four function groups in society: citizens environmentally exposed to the hazards causing heavy metals toxicity; employees exposed to heavy metals; their employers; and physicians providing medical care to individuals who suffer adverse health effects from these hazards. Pregnant women and children, who are particularly vulnerable to the health effects of these hazards, are included in the first two groups. The impact of these amendments on exposed individuals will be positive, because reporting will result in public health actions to identify and then to prevent or control hazardous conditions posed to others. Employers will benefit from public health follow-up to laboratory reports because the identification and control of hazards will help ensure a healthy workforce and reduce insurance costs. The social impact on physicians will include heightened awareness of these hazards and their potential impact on the health status of physicians' patients.

### Economic Impact

The reporting of test results and supplemental data by clinical laboratories will constitute minimal economic impact to these institutions. The Department estimates the number of reports from the 35 certified clinical laboratories in New Jersey combined to be 2,000 for lead, 50 for arsenic, and 100 for mercury per year, based on past experience. The highest number of cadmium reports in any past year was 163, in 1990; this is expected to increase, both because the reporting level is being lowered and because cadmium biological monitoring is now required by Federal OSHA for those with occupational exposure to cadmium. These index cases will allow the Department of Health to identify a much larger number of additional cases. The economic benefits from reducing occupational and environmental disease among workers and members of the public is significant, not only to those affected persons, but to companies who must pay out costs to injured persons. Costs from lost wages, workers compensation, and medical expenses will be reduced with a reduction in occupational and environmental diseases.

### Regulatory Flexibility Analysis

Amended rule N.J.A.C. 8:44-2.11 applies to clinical laboratories, including those with less than 100 employees. The reporting requirement for N.J.A.C. 8:44-2.11 is simple and can be done by filling in a one-page form, provided by the Department. No other recordkeeping or compliance requirements are involved. There are no initial capital costs. The only cost to the business is a stamp for the envelope and minimal staff time to fill out the form. In order to promote the public health as described in the Social Impact above, no exceptions or lesser requirements based upon business size can be provided.

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

8:44-2.11 Reporting by laboratory supervisors

**(a)** Laboratory supervisors shall:

[(a)-(c)]**1.-3.** (No change in text.)

[(d)]**(b)** Laboratory supervisors shall immediately report to the State Department of Health, results of laboratory examinations in-

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dicating levels of hazardous substances in blood and urine equal to or greater than the following:

1.-3. (No change.)

4. Cadmium

i. Blood cadmium levels equal to or greater than [5] **five** ug/L **of whole blood**;

ii. Urine cadmium levels equal to or greater than [10 ug/L] **three ug/gram creatinine**.

**(c) The reports required by (b) above shall contain the result of the laboratory examination, including units; the type of specimen tested; the sample number and date the sample was collected and analyzed; the name, address, telephone number, sex, and date of birth or age of the patient; the name, address, and telephone number of the employer; the patient occupation; the name, address, telephone number, and name of the medical facility of the requesting physician; and the name, address, telephone number of testing laboratory.**

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# RULE ADOPTIONS

## COMMUNITY AFFAIRS

## (a)

### NEW JERSEY COUNCIL ON AFFORDABLE HOUSING

### Procedural Rules

### Adopted Repeal and New Rules: N.J.A.C. 5:91-14

Proposed: March 15, 1993 at 25 N.J.R. 1118(a).

Adopted: July 7, 1993 by the New Jersey Council on Affordable Housing, Reneé Reiss, Secretary.

Filed: July 24, 1993 as R.1993 d.407, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3) **and with the proposed amendments to N.J.A.C. 5:92-1.1 and proposed new rules N.J.A.C. 5:93 not adopted at this time.**

Authority: N.J.S.A. 52:27D-301 et seq., specifically 52:27D-307.

Effective Date: August 16, 1993.

Expiration Date: December 7, 1997.

**Summary** of Public Comments and Agency Responses:

The following individuals submitted written and/or verbal comments, which are on file at the Office of the Council on Affordable Housing.

Jeffrey Surenian, Esq.
Lomell, Muccifori, Adler, Ravaschiere, Amabile & Pehlivanian
Toms River, New Jersey

Steven Shaw, Esq.
Seven The Boardwalk
Sparta, New Jersey

The great majority of comments on the proposed new rules were directed at N.J.A.C. 5:93, Substantive Rules, rather than on N.J.A.C. 5:91-14. As the Council is still reviewing the comments received on the former, it was determined that the adoption of N.J.A.C. 5:91-14 could proceed. The adoption of N.J.A.C. 5:93 will occur at a later time.

**Summary** of Hearing Officer Recommendations and Agency Responses:

Hearings on the proposed new rules were held on April 14, 15 and 22, 1993, with either Christiana Foglio or Art Bernard serving as hearing officers. As no hearing comments were directed at proposed N.J.A.C. 5:91-14, no hearing officer recommendations were made concerning those rules. Hearing officer recommendations, if any, and agency responses covering N.J.A.C. 5:92-1.1 and 5:93 will be summarized in their subsequent adoption. The hearing record may be reviewed by contacting Art Bernard, Council on Affordable Housing, CN 813, Trenton, NJ 08625.

**N.J.A.C. 5:91-14 Interim Certification**

COMMENT: N.J.A.C. 5:91-14.2(a) provides that municipalities, that have petitioned for but have not yet received substantive certification for the 1987-1993 housing need, may now move to amend their petition to address their 1987-1999 housing obligation. In a number of instances the new obligation is lower than the prior obligation. In some of these cases there are objectors in the process who have been participating in good faith so their site will be designated as an inclusionary site. It is not reasonable to now create the situation where the objector's site can be arbitrarily dismissed because the municipal obligation has been reduced. These current objectors in the process who have participated in good faith need to be accommodated in this rule proposal.

RESPONSE: Participation in the Council's process does not guarantee inclusion in the municipal housing element and fair share plan. Housing elements have changed over the years to include and exclude sites as a result of the Council's mediation process. In its review of housing elements, the Council shall be looking for sites that are available, developable, approvable and suitable. There is nothing in the proposed rules that prevents a developer with an inclusionary site to object to any change a municipality may seek as a result of the proposed 1987-1999 housing obligations.

COMMENT: N.J.A.C. 5:91-14.2(d) requires any municipality that receives certification for the 1987-1993 housing obligation to re-petition for substantive certification to address its 1987-1999 housing obligation. Since some of the obligations have been reduced, is COAH creating the opportunity for the elimination of inclusionary sites and affordable housing opportunities?

RESPONSE: No. This provision is for municipalities that have an increased obligation as a result of the 1987-1999 calculations.

COMMENT: The enactment of the 1,000 cap means that the Council cannot effectively limit the protective impact of its certification for two years as contemplated in N.J.A.C. 5:91-14.2(d) for municipalities affected by the 1,000 cap legislation.

RESPONSE: A municipality that had a fair share of 1,000 or more based on the 1987-1993 estimates of housing need could receive a six year certification based on the legislation that limits the six year responsibility to 1,000. However, where a municipality with a 1987 to 1999 obligation of 1,000 units or more decides to seek certification of its 1987 to 1993 obligations under these rules and such a municipality's 1987 to 1999 obligation changes in character (for example, the 1987 to 1999 obligation requires a greater new construction component than has been certified), the interim certification is necessarily limited to two years so that the municipality may address its changed obligation within the parameters set down by the 1,000 unit cap legislation.

COMMENT: The Council should not require a municipality attempting to receive substantive certification of a 1,000 unit plan to recalculate its rehabilitation component and new construction component based on the proposed 1987-1999 housing obligation.

RESPONSE: Once the need has been recalculated and adopted, the Council cannot certify a housing element that does not address the need. This applies to municipalities with small and large housing obligations.

After the expiration of the comment period, the Council received several telephone inquiries asking whether the Council required the housing element, referenced in N.J.A.C. 5:91-14, to be adopted. This section of the Council's procedural rules should be read in conjunction with N.J.A.C. 5:91-2.2, which states that the Council will not accept a housing element unless it has been adopted. Therefore, the housing element must be adopted.

**Summary** of Changes Upon Adoption:

Throughout the contents of these rules, the words "this rule" refers to N.J.A.C. 5:93. Since this rule will not be adopted, as originally planned with this interim procedures rule, the Council has substituted "N.J.A.C. 5:93."

There is also a change wherever there is reference to N.J.A.C. 5:92. This has been corrected to read N.J.A.C. 5:93, since these will be the new substantive rules of the Council.

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

SUBCHAPTER 14. INTERIM PROCEDURES

5:91-14.1 Interim substantive certification

(a) A municipality that has received substantive certification from the Council for a housing element and fair share plan addressing the municipality's affordable housing obligation for 1987-1993 may move for an interim substantive certification if its certification expires prior to or within nine months after the effective date of *[this rule]* ***N.J.A.C. 5:93***. If a municipality's judgment of repose has expired, the municipality may, within four months of the effective date of *[this rule]* ***N.J.A.C. 5:93***, also file such a motion providing no exclusionary zoning lawsuit has been filed against the municipality. The motion seeking interim certification must:

1. Comply with the requirements of N.J.A.C. 5:91-12;

2. Be served upon all objectors and/or litigants that participated in the substantive certification or court settlement process; and

3. Be accompanied by:

i. The municipality's current housing element and fair share plan;

ii. A resolution of the governing body of the municipality expressing the intention to submit to the Council, within nine months following the effective date of *[this rule]* ***N.J.A.C. 5:93***, a housing element and fair share plan addressing the municipality's fair share housing obligation;

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iii. A proposed schedule for this submission;

iv. A statement as to the progress of the municipality's compliance with the terms of substantive certification; and

v. Any additional information the Council may require.

(b) The Council will issue interim substantive certification for a period of time not to exceed nine months following the effective date of *[this rule]* ***N.J.A.C. 5:93*** that responds to the submitted municipal schedule for filing its housing element and fair share plan if no objection is filed to the municipality's motion for interim substantive certification. The Council will condition its grant of substantive certification with any conditions it deems necessary or appropriate in order to insure continued compliance with the terms of substantive certification and the satisfaction of the municipal fair share obligation.

(c) Objections filed to a municipality's motion for interim substantive certification shall set out how the municipality has failed to comply with the terms of substantive certification or otherwise failed to satisfy its fair share obligation and also articulate what relief is requested of the Council.

(d) When interim substantive certification is granted, a municipality shall leave all ordinances implementing its original substantive certification in effect for the interim substantive certification period, unless the municipality can demonstrate good cause why the ordinances should not remain in effect.

(e) If a municipality received a judgment of repose that expires up to nine months after the effective date of *[this rule]* ***N.J.A.C. 5:93***, the municipality should apply to the Court that issued the judgment for relief prior to the expiration of its judgment of repose. The Council will consider a motion for interim certification if the Court transfers the request to the Council. In such cases, the procedures and criteria set forth above shall apply.

5:91-14.2 Municipalities that have not received substantive certification

(a) A municipality that has petitioned for substantive certification of a housing element and fair share plan designed to address its 1987-1993 obligation, but has not received a final determination of the Council on its plan by the effective date of *[this rule]* ***N.J.A.C. 5:93***, may either:

1. Move to amend its housing element and fair share plan to address its 1987-1999 obligation pursuant to N.J.A.C. *[5:92]* ***5:93*** and repetition for certification of the amended plan; or

2. Choose to continue to seek substantive certification on its 1987-1993 obligation.

(b) A municipal motion to amend its housing element and fair share plan to address its 1987-1999 obligation pursuant to N.J.A.C. *[5:92]* ***5:93*** shall be accompanied by a resolution of the governing body of the municipality expressing the intention to submit to the Council, within nine months following the effective date of *[this rule]* ***N.J.A.C. 5:93***, an amended housing element and fair share plan addressing the municipality's 1987-1999 obligation pursuant to N.J.A.C. *[5:92]* ***5:93***; a proposed schedule for this submission; and the intention to repetition for substantive certification within the nine month period.

(c) When granting such motion, the Council will set out a schedule for the municipal submission of its housing element and fair share plan and will require the municipality to repetition for substantive certification of the new housing element and fair share plan upon this filing.

(d) The Council will condition any grant of substantive certification for a municipal housing element and fair share plan that addresses only the 1987-1993 fair share obligation by a requirement that the municipality file a housing element and fair share plan addressing its 1987-1999 obligation pursuant to N.J.A.C. *[5:92]* ***5:93*** and petition for the substantive certification of that housing element and plan within two years of the date of the granting of substantive certification of the 1987-1993 plan.

5:91-14.3 Other municipalities

(a) A municipality that filed its housing element and fair share plan with the Council more than two years prior to the effective date of *[this rule]* ***N.J.A.C. 5:93***, but did not petition for substantive certification prior to the effective date of *[this rule]* ***N.J.A.C. 5:93***, must file a new housing element and fair share plan addressing its 1987-1999 obligation pursuant to N.J.A.C. *[5:92]* ***5:93*** and petition for substantive certification prior to an exclusionary lawsuit to re-enter the Council's process.

(b) A municipality that has filed a housing element and fair share plan less than two years prior to the effective date of *[this rule]* ***N.J.A.C. 5:93*** may seek to extend the period of protection afforded by N.J.S.A. 52:27D-313 for up to nine months following the effective date of *[this rule]* ***N.J.A.C. 5:93*** in order to address its 1987-1999 obligation pursuant to N.J.A.C. *[5:92]* ***5:93***. To seek such an extension, the municipality shall file a resolution of the governing body within whichever of the following dates occurs earlier: two years of the initial filing of the municipal housing element and fair share plan; or four months of the effective date of *[this rule]* ***N.J.A.C. 5:93***. In addition to a schedule for submitting a housing element and fair share plan, the governing body's resolution shall state an intent to petition for substantive certification upon filing the housing element and fair share plan.

(c) The Council shall review the municipality's resolution of intent and grant a schedule for the municipal submission of the housing element and fair share plan conditioned on the municipality's petitioning for substantive certification upon filing its submission. The schedule for submitting the housing element and fair share plan shall require the filing and petition to occur within nine months of the effective date of *[this rule]* ***N.J.A.C. 5:93***.

# ENVIRONMENTAL PROTECTION AND ENERGY

## (a)

## POLICY AND PLANNING

### Environmental Hazardous Substances List and Industrial Survey List

### Adopted Amendments: N.J.A.C. 7:1F-2.2 and Appendix A, and N.J.A.C. 7:1G-2.1 and 6.4

Proposed: June 7, 1993 at 25 N.J.R. 2166(a).

Adopted: July 21, 1993 by Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Filed: July 26, 1993 as R.1993 d.408, **without change.**

Authority: N.J.S.A. 13:1D-9, 34:5A-1 et seq. and 26:2C-1 et seq.

DEPE Docket Number: 33-93-04.

Effective Date: August 16, 1993.

Expiration Date: April 16, 1997, N.J.A.C. 7:1F;
September 29, 1994, N.J.A.C. 7:1G.

**Summary** of Public Comments and Agency Responses:
**No comments were received.**

**Full text** of the adopted amendments follows:

7:1F-2.2 Access to information; non-disclosure; hearing before disclosure

(a) (No change.)

(b) Information for which a confidentiality claim has been asserted shall remain subject to the confidentiality requirements of this subchapter if the substance for which the claim was asserted is subsequently deleted from Appendix A of this chapter.

(c) (No change in text.)

(d) A request for an adjudicatory hearing under (c) above shall contain the following information:

1.-4. (No change.)

(e) The Department may deny a request for an adjudicatory hearing under (c) above if:

1.-4. (No change.)

Recodify existing (e) to (g) as (f) to (h) (No change in text.)

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APPENDIX A
TABLE 1. SELECTED SUBSTANCES

All chemical compounds and/or complexes containing a selected substance (including organic, inorganic and organo-metallics) are to be reported under the given CAS code number and identified on the survey form.

...

| CAS NO. | INORGANICS (INCLUDE SALTS OF THESE COMPOUNDS) |
|---|---|
| ... | |
| 7440-50-8 | Copper, except compounds:<br>C.I. Pigment Blue 15,<br>Phthalocyanine Blue (CAS No. 147-14-8)<br>C.I. Pigment Green 7,<br>Phthalocyanine Green (CAS No. 1328-53-6)<br>C.I. Pigment Green 36,<br>Phthalocyanine Green (CAS No. 14302-13-7) |

...

7:1G-2.1 Designation of substances

The following substances and corresponding Chemical Abstract Services (CAS) numbers are designated as Environmental Hazardous Substances pursuant to the Act. Each substance has further been identified according to the classifications, in N.J.A.C. 7:1G-2.2. Substances may have numerous synonyms which are not included herein.

| Chemical | CAS Number | Group Number |
|---|---|---|
| ... | | |
| COPPER AND COMPOUNDS | | |
| except: | 7440-50-8 | 19 |
| C.I. Pigment Blue 15, Phthalocyanine Blue | 147-14-8 | |
| C.I. Pigment Green 7, Phthalocyanine Green | 1328-53-6 | |
| C.I. Pigment Green 36, Phthalocyanine Green | 14302-13-7 | |

...

7:1G-6.4 General provisions

(a) Exept as provided in N.J.A.C. 7:1G-6.15, the Department shall not disclose any trade secret claim and supporting information, that is pending or has been approved. This non-disclosure requirement shall apply to trade secret claims for substances which were subsequently deleted from the environmental hazardous substances list.

(b)-(k) (No change.)

---

## (a)

## ENVIRONMENTAL REGULATION

### Surface Water Quality Standards

### Adopted Amendments: N.J.A.C. 7:9-4.14 and 4.15

Proposed: February 1, 1993 at 25 N.J.R. 405(a).

Adopted: July 26, 1993 by Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.

Filed: July 26, 1993 as R.1993 d.415, **without change, but with portions not adopted at this time.**

Authority: N.J.S.A. 13:1D-1 et seq., 58:10A-1 et seq., and 58:11A-1 et seq.

DEPE Docket Number: 63-92-12.

Effective Date: August 16, 1993.

Expiration Date: January 18, 1996.

**Summary** of Hearing Officer's Recommendations and Agency Responses:

The New Jersey Department of Environmental Protection and Energy (Department) is adopting amendments to the State's Surface Water Quality Standards (SWQS) at N.J.A.C. 7:9-4.14(c) and 7:9-4.15(b)-(h). The amendments were proposed on February 1, 1993, at 25 N.J.R. 405(a). The proposed amendments include provisions regarding: (1) surface water reclassifications and changes in antidegradation designations; (2) prohibition of mixing zones for bacterial indicators; and (3) thermal criteria for saline estuarine (SE) bays and trout production (FW2-TP) waters. A public hearing was held on the proposed amendments at the Department in Trenton on March 4, 1993. The public comment period on the amendments closed on March 12, 1993.

Administrator Martin Bierbaum served as the hearing officer at the public hearing held March 4, 1993. As a result of the public hearing, Administrator Bierbaum recommended that the Department adopt the rule as discussed below. The Department agrees with the recommendation. Interested persons may inspect the public hearing record, or obtain a copy on payment of the Department's normal copying charges, by contacting:

Janis E. Hoagland, Esq.
Office of Legal Affairs
Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

The Department is continuing to evaluate the public comments concerning the following provisions of the proposed amendments and therefore has not yet adopted them: (1) Category One antidegradation designation of the portion of the Wallkill River within the confines of the Wallkill River National Wildlife Refuge at N.J.A.C. 7:9-4.15(g); (2) FW2-NT classification of the stretch of the Wallkill River from the outlet of Franklin Pond to boundary of the Wallkill River National Wildlife Refuge also at N.J.A.C. 7:9-4.15(g); and (3) prohibition of mixing zones for bacterial indicators at N.J.A.C. 7:9-4.5(c). Although the Department is not presently adopting the proposed reclassification of the mainstem Wallkill River, the proposed amendments regarding the Hamburg Mountain and Ogdensburg tributaries to the Wallkill River are being adopted because no comments were received in opposition to the classifications of these tributaries. The Department will consider the comments regarding the remainder of the proposed amendments and will, at a later date, adopt those amendments it deems appropriate.

The following amendments are being adopted at this time: (1) surface water classifications in N.J.A.C. 7:9-4.15(c)-(h) based on trout fisheries data, (the only exception being the mainstem Wallkill River as noted above); (2) Category One (C1) antidegradation designation of the stretch of the Rockaway River from Washington Pond outlet downstream to Route 46 bridge; (3) provisions at N.J.A.C. 7:9-4.14(c)12 and 7:9-4.15(b)5 to reflect that lakes, ponds, and reservoirs can potentially be classified as FW2-TP and that thermal criteria and heat dissipation areas apply to such waterbodies; (4) thermal criteria for saline estuarine (SE) bays at N.J.A.C. 7:9-4.14(c)12; and (5) reclassification to less restrictive uses portions of Assunpink Creek and Posts Brook based on recalculation of the Incidence of Occurrence table confirmed by new fisheries data at N.J.A.C. 7:9-4.15.

**Summary** of Public Comments and Agency Responses:

The following persons submitted oral or written comments during the comment period with respect to the proposed amendments herein adopted:

1. Abigail Fair, Association of New Jersey Environmental Commissions
2. Clifford G. Day, Fish and Wildlife Service, U.S. Department of the Interior
3. Richard P. Kane, Director of Conservation, New Jersey Audubon Society
4. Anne Leahy
5. Mariann J. Bucina
6. Louis Farrelly
7. Donald Englander
8. Gary Wayne Loew
9. Karen Parrish
10. Newell S. Doty
11. Susannah and Tom Graedel
12. Richard and Helen M. Brede
13. William Aiello
14. Doris Stinson
15. Wendy Malmed
16. Erika Varnai
17. Edward K. and Lucy A. Kaprelian
18. Marjorie and Richard Parsons
19. Kristine West
20. Kenneth West

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21. Charles and Ann Brackett
22. A.J. Rapp
23. Lawrence and Marian Mundy
24. Marilyn F. Althoff, M.D.
25. Samuel F. Redick
26. Joseph W. and Kathleen W. Huemer
27. Daniel W. Miller, President, Harding Service Corporation
28. Julia Somers, Executive Director, Great Swamp Watershed Association
29. Diane H. Dayson, Superintendent, Morristown National Historical Park, U.S. Department of the Interior
30. John Dannenbaum, on behalf of the Mendham Township Environmental Commission
31. Louisa C. Spencer, Environmental Defense Fund
32. Eugene Dunworth, Jr., Township Administrator, Township of Morris
33. Mary Arnold, State of New Jersey Natural Areas Council
34. John Knapp, Jr., Vice President, Morris Highlands Audubon Society
35. Charles Lenchtz, Rockaway Township Environmental Commission

The Department also received many comments from individuals in support of the reclassifications after the close of the comment period. A summary of the comments timely received and the Department's responses follow. The number(s) in parentheses after each comment identifies the respective commenter(s) listed above.

1. COMMENT: Several commenters expressed support for the proposal to change the classification and antidegradation status of the Passaic River, from its source to Interstate 287 bridge (except tributaries listed separately), from FW2-TM(C2) to FW2-TP(C1) (1-3)

RESPONSE: The Department acknowledges the commenters' support and has adopted the change in classification and antidegradation status.

2. COMMENT: Many individuals commented in support of the proposed change in classification and antidegradation status of the waters of the Passaic River from Mendham to Route 202 from FW2-TM(C2) to FW2-TP(C1) because of the environmentally sensitive nature of the Great Swamp. (4-30)

RESPONSE: The Department acknowledges the commenters' support and has adopted the change in classification and antidegradation status. It should be noted, however, that the change in classification and antidegradation status was based on field surveys demonstrating that this portion of the Passaic was a trout production water.

3. COMMENT: The Department's proposal to reclassify a portion of the Passaic River from Route 202 to Mendham from FW2-TM(C2) to FW2-TP(C1) also included reclassification of the tributaries to the Passaic River to FW2-TP(C1). (29)

RESPONSE: With the exception of Indian Grove Brook, the Department did not propose to amend N.J.A.C. 7:9-4.15 to reclassify the tributaries to the stretch of the Passaic River from Route 202 to Mendham to FW2-TP(C1).

4. COMMENT: The Passaic River, above Route 287, qualifies as an Outstanding National Resource Water (ONRW) according to the Federal Clean Water Act because it flows through the Morristown National Historic Park and the New Jersey Audubon Society Scherman-Hoffman Wildlife Sanctuaries, and it is a tributary to the Great Swamp National Wildlife Refuge (NWR) which is also an ONRW. (3)

RESPONSE: New Jersey's Surface Water Quality Standards incorporate three antidegradation categories that provide different levels of protection from degradation. The least protective of these categories is Category 2. Most waters in New Jersey are classified as Category 2 and are regulated under that policy to ensure that water quality changes are restricted to the range of quality which fully protects all designated and existing uses. Category 1 antidegradation waters receive additional protection and are regulated to keep water quality that is better than that necessary to protect the designated and existing uses from significant degradation. Finally, ONRWs receive the highest level of protection and are regulated to ensure that there are no changes to water quality, except toward natural conditions. Outstanding National Resource Waters are defined at N.J.A.C. 7:9-4.4 as high quality waters that constitute an outstanding national resource (for example, waters of National/State parks and wildlife refuges and waters of exceptional recreational or ecological significance) and are listed in New Jersey's SWQS at N.J.A.C. 7:9-4.15(i). Implicit in this definition is a recognition that not all waters described in the definition as qualifying for designation as an ONRW are so designated. Currently, the Department has designated only FW1 and PL (Pinelands) waters as ONRWs. FW1 waters were included because they are waters originating and wholly contained within public lands and are intended to be preserved for posterity. PL waters were included because the Federal and State legislation establishing the Pinelands indicated that these waters were an outstanding national resource that was to be preserved. Generally, the Department believes that it has correctly identified and designated those waters which should be classified as ONRWs.

The Department has reclassified the Passaic River above Route 287 as Category 1 as part of this adoption. This reclassification is believed to be a more appropriate action than reclassification as ONRW. The Department invites public comment on the appropriateness of designating this portion of the Passaic River as a Category 1 water as opposed to an ONRW. In order to clarify the record it should be noted that the commenter has incorrectly stated that the Passaic River is a tributary to the Great Swamp National Wildlife Refuge. In fact, the waters within the Great Swamp NWR are tributary to the Passaic River. Additionally, none of the waters within the Great Swamp NWR are designated as ONRWs.

5. COMMENT: The Department should designate the waters of the Great Swamp NWR as ONRWs under N.J.A.C. 7:9-4.15(i). (3)

RESPONSE: The Great Swamp Watershed Advisory Committee (GSWAC), in its April 1993 "Final Report of the Great Swamp Advisory Committee to the New Jersey Department of Environmental Protection and Energy," formally recommended that the Department should designate the waters of the Great Swamp NWR as ONRWs. It also recommended that the Department designate all waters tributary to the Great Swamp NWR as C1, but only if a policy of no net increase in pollutant loadings and stormwater flows is not adopted and enforced. The GSWAC's recommendations are being reviewed and evaluated. The public is invited to comment on the appropriateness of designating these waters as ONRWs. Currently, waters within the Great Swamp are designated as Category 1.

6. COMMENT: The Department should designate all tributary waters flowing in or to the Great Swamp NWR as Category One (C1) waters to protect the water quality. (2, 3, 31)

RESPONSE: In the report referenced in the Department's response to Comment 5, the GSWAC also recommended that the Department designate all waters tributary to the Great Swamp NWR as C1. Under the existing regulations, discharges upstream of C1 waters must be regulated to ensure protection of the C1 waters. As discussed in the response to Comment 5, the Department is reviewing the GSWAC's recommendations.

7. COMMENT: One commenter disagreed with the recommendations of the Great Swamp Watershed Advisory Committee regarding blanket upgrading of Great Swamp NWR tributaries to C1. (32)

RESPONSE: The Department acknowledges this difference of opinion. However, the GSWAC is recommending to the Department that all waters tributary to the Great Swamp NWR be designated as C1 only if a policy of no net increase in pollutant loadings and stormwater flows is not adopted and enforced.

8. COMMENT: One commenter expressed support for the upgrading of the classification of Ohio Brook in Morris Township from FW2-NT to FW2-TM since it flows through the Morris County Park Commission's Fosterfields, providing recreational opportunities and aesthetic enjoyment. (33)

RESPONSE: The Department acknowledges the commenter's support and has adopted the change in classification.

9. COMMENT: Several commenters supported the proposed change in classification and antidegradation status of the Rockaway River, from Washington Pond outlet in Dover to the Route 46 bridge, from FW2-NT(C2) to FW2-TM(C1). (1, 31, 34)

RESPONSE: The Department acknowledges the commenter's support and has adopted the change in classification and antidegradation status.

10. COMMENT: Two commenters expressed support for the proposed change in the classification and antidegradation status of Beaver Brook (Meriden) from FW2-TM(C2) to FW2-TP(C1). (1, 35)

RESPONSE: The Department acknowledges the commenter's support and has adopted the change in classification and antidegradation status.

11. COMMENT: One commenter supported the change in the classification and antidegradation status of Hibernia Brook, source to first Green Pond Road bridge downstream of Lake Emma, from FW2-TM(C2) to FW2-TP(C1). (35)

RESPONSE: The Department acknowledges the commenter's support and has adopted the change in classification and antidegradation status.

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12. COMMENT: Several commenters expressed general support for the amendments that upgrade the classifications and existing uses. (1, 2, 9)

RESPONSE: The Department acknowledges the commenter's support and has adopted the noncontroversial proposed changes in classification and antidegradation status.

**Full text** of the adoption follows (**please note** that the proposed amendments to N.J.A.C. 7:9-4.15(g), Wallkill River, with the exception of the Wallkill River tributaries, may be adopted at a later date, as discussed above):

7:9-4.14 Surface water quality criteria

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

(c) Surface Water Quality Criteria for FW2, SE and SC Waters:

Surface Water Quality Criteria for FW2, SE and SC Waters
(Expressed as maximum concentrations unless otherwise noted)

| Substance | Criteria | Classifications |
|---|---|---|
| 1.-11. (No change.) | | |
| 12. Temperature and Heat Dissipation Areas | i. Thermal Alterations (Temperatures shall be measured outside of heat dissipation areas) | |
| | (1) (No change.) | |
| | (2) Lakes, Ponds or Reservoirs | |
| | (i) No thermal alterations except where it can be shown to be beneficial to the designated and existing uses. | FW2-TM, FW2-TP |
| | (ii) (No change.) | |
| | (3) Saline Bays—No thermal alterations which would cause temperatures to deviate from ambient by more than 2.2°C (4°F), from September through May, nor more than 0.8°C (1.5°F) from June through August nor cause temperatures to exceed 29.4°C (85°F). | All SE |
| | (4) Coastal Waters—No direct heat additions within 1500 feet of the shoreline. No thermal alterations which would cause temperatures to deviate from ambient temperatures by more than 2.2°C (4°F) from September through May, nor more than 0.8°C (1.5°F) from June through August, nor which would cause temperatures to exceed 26.7°C (80°F). | SC |
| | ii. Heat Dissipation Areas | |
| | (1) (No change.) | |
| | (2) Lakes, Ponds, Reservoirs, Bays or Coastal Waters: Heat dissipation areas will be developed on a case-by-case basis. | FW2-TP, FW2-TM, FW2-NT, All SE, SC |
| 13.-15. (No change.) | | |

(d) (No change.)

7:9-4.15 Surface water classifications for the waters of the State of New Jersey

(a) (No change.)

(b) The following are instructions for the use of Tables 1 through 5 found in N.J.A.C. 7:9-4.15(c) through (g) respectively:

1.-4. (No change.)

5. To find unnamed waterways or waterbodies or named waterways or waterbodies which do not appear in the listing, use the following instructions:

i. (No change.)

ii. All freshwater lakes, ponds and reservoirs that are five or more acres in surface area, that are not located entirely within the Pinelands Area boundaries (see (b)5vii below) and that are not specifically listed as FW2-TP or FW2-TM are classified as FW2-NT. This includes lakes, ponds and reservoirs on segments of streams which are classified as FW2-TM or FW2-TP such as Saxton Lake on the Musconetcong River. If the waterbody could be a C1 water, also check (b)5vi below.

iii.-vii. (No change.)

6.-7. (No change.)

(c) The surface water classifications in Table 1 are for waters of the Atlantic Coastal Basin:

TABLE 1

| Waterbody | Classification |
|---|---|
| ... | |
| CLEAR STREAM (Jackson)—Entire length | FW2-NT |
| ... | |
| LONG BROOK (Jackson)—Entire length | PL |
| ... | |
| MINGAMAHONE BROOK | |
| MAINSTEM | |
| (Farmingdale)—Entire length, except segments described below | FW2-TM |
| (Allaire State Park)—Brook and tributaries within the boundaries of Allaire State Park | FW2-TM(C1) |
| EAST BRANCH | |
| (Farmingdale)—Source to confluence with mainstem north of Farmingdale | FW2-NT |
| ... | |
| REEVY BRANCH—See SHARK RIVER | |
| ... | |
| SHARK RIVER | |
| (Colts Neck)—Source to Rt. 33 | FW2-NT |
| (Neptune)—Rt. 33 to Brighton Ave. bridge, Glendola | FW2-TM/SE1 |
| (Glendola)—Brighton Ave. bridge to Atlantic Ocean | FW2-NT/SE1 |
| TRIBUTARY | |
| REEVY BRANCH (Reevytown)—Source to confluence with Shark River | FW2-NT |
| ... | |
| TAUGH CREEK | |
| (Whitesboro)—Entire length, except segment described below | SE1(C1) |
| (Whitesboro)—Portions outside the boundaries of Marmora Wildlife Management Area | SE1 |
| ... | |
| TOMS RIVER | |
| MAINSTEM | |
| ... | |
| TRIBUTARIES, TOMS RIVER | |
| ... | |
| DOVE'S MILL BRANCH | |
| ... | |
| MAPLE ROOT BRANCH (Jackson)—Source to confluence with Toms River | PL |
| ... | |

(d) The surface water classifications in Table 2 are for waters of the Delaware River Basin:

TABLE 2

| Waterbody | Classification |
|---|---|
| ... | |
| ASSUNPINK CREEK | |
| (Trenton)—Source to confluence with the Delaware River, except segments described separately below | FW2-NT |
| (Roosevelt)—Creek and those tributaries within the boundaries of the Assunpink Wildlife Management Area | FW2-NT(C1) |
| (Quaker Bridge)—Portions of the creek within the boundaries of Van Ness Refuge | FW2-NT(C1) |
| ... | |
| BARKERS MILL BROOK (Independence)—Entire length | FW2-TP(C1) |
| ... | |
| BEAVER BROOK (Jefferson)—Source to, but not including, Lake Shawnee | FW2-NT |
| ... | |
| BIG FLAT BROOK | |
| (Montague)—Sawmill Pond to confluence with Parker Brook, except segments described under the listing for Flat Brook, below | FW2-NT(C1) |
| (Sandyston)—Confluence with Parker Brook, through the Blewitt Tract, to the confluence with Flat Brook, except tributaries described under the listing for Flat Brook, below | FW2-TP(C1) |
| (Tuttles Corner)—Outlet stream from Lake Ashroe to its confluence with Big Flat Brook | FW2-TP(C1) |
| ... | |

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DELAWARE RIVER
MAIN STEM
...
TRIBUTARIES, DELAWARE RIVER
...
(Knowlton)—Source, north of Hope-Delaware Road, to confluence with the Delaware River 0.5 mile south of Ramseysburg FW2-TP(C1)
...
FIDDLERS CREEK (Titusville)—Entire length FW2-TM
...
FLAT BROOK
(Flatbrook-Roy)—Confluence of Big Flat Brook and Little Flat Brook to the boundary of Flatbrook-Roy Wildlife Management Area, except segments described below FW2-TP(C1)
(Flatbrookville)—Flatbrook-Roy Wildlife Management Area boundary to Delaware River, except segments described below FW2-TM
(Walpack)—Segment of the Brook within Walpack Wildlife Management Area FW2-TM(C1)
(Stokes State Forest)—Two tributaries to Flat Brook which originate along Struble Road in Stokes State Forest to their confluences with Flat Brook within the boundaries of Flatbrook-Roy Wildlife Management Area FW1(tm)
(High Point)—All surface water of the Flat Brook drainage area within the boundaries of High Point State Park and Stokes State Forest, except the following waters: FW1
1. Saw Mill Pond and Big Flat Brook downstream to the confluence with Flat Brook;
2.-8. (No change.)
9. Lake Shawanni and its outlet stream to its confluence with Flat Brook;
10. (No change.)
...
HAKIHOKAKE CREEK (Milford)—Entire length including headwaters known as Little York Creek FW2-TP(C1)
TRIBUTARIES
(Wydner)—Source to confluence with Hakihokake Creek west of York Road FW2-TP(C1)
HALFWAY HOUSE BROOK (Franklin)—Entire length FW2-TP(C1)
...
KNOWLTON BROOK (Knowlton)—Entire length FW2-TP(C1)
KURTENBACH'S BROOK (Waterloo)—Entire length FW2-TP(C1)
...
LITTLE FLAT BROOK
(High Point State Park)—Source to boundary of High Point State Park FW1(tp)
(Layton)—State park boundary to, but not including tributary described below, to confluence with Big Flat Brook FW2-TP(C1)
(Flatbrook-Roy)—Tributary which originates north of Bevans-Layton Rd. downstream to the first pond adjacent to the Fish and Game headquarters building FW1(tp)
...
LOPATCONG CREEK
...
TRIBUTARY
(Uniontown)—Entire length FW2-TP(C1)
...
MERRILL CREEK (Harmony)—Entire length, but not including Merrill Creek Reservior FW2-TP(1)
MERRILL CREEK RESERVOIR (Harmony) FW2-TM
...
MINE BROOK
(Mt. Olive)—Source to, but not including, Upper Mine Brook Reservoir, downstream to Lower Mine Brook Reservoir outlet FW2-TM
(Mt. Olive)—Lower Mine Brook Reservoir outlet downstream to Drakestown Road bridge FW2-TP(C1)
(Hackettstown)—Drakestown Road bridge downstream to confluence with Musconetcong River FW2-TM
TRIBUTARIES
(Drakestown)—Source downstream to, but not including, Burd Reservoir FW2-TP(C1)
(Drakestown)—Burd Reservoir downstream to confluence with Mine Brook FW2-TM
(Washington)—Entire length of tributary which joins Mine Brook approximately 280 yards upstream of the confluence with the Musconetcong River FW2-TP(C1)
...
MUDDY BROOK (Hope)—Entire length FW2-NT
...
MUSCONETCONG RIVER
(Hackettstown)—Lake Hopatcong dam to Delaware River, except tributaries described below FW2-TM
TRIBUTARIES
(Anderson)—Entire length FW2-TP(C1)
...
(Waterloo)—Tributary west of Kurtenbach's Brook from source downstream to Waterloo Valley Road bridge FW2-TP(C1)
...
PAULINS KILL
EAST BRANCH
...
TRIBUTARY EAST BRANCH
...
WEST BRANCH
...
MAIN STEM
...
TRIBUTARIES, MAIN STEM
(Blairstown)—Entire length of tributary east of Walnut Valley FW2-TM
...
PENNSAUKEN CREEK (Cinnaminson)—Entire length FW2-NT
PEQUEST RIVER
...
TRIBUTARIES
(Petersburg)—Headwaters and tributaries downstream to Ryan Road bridge FW2-TP(C1)
...
POPHANDUSING BROOK (Belvidere)
(Hazen)—Source downstream to Route 519 bridge FW2-TP(C1)
(Belvidere)—Route 519 bridge downstream to confluence with the Delaware River FW2-TM
...
STONY BROOK (Knowlton)—Entire length FW2-TP(C1)
...

(e) The surface water classifications in Table 3 are for waters of the Passaic, Hackensack and New York Harbor Complex Basin:

TABLE 3

| Waterbody | Classification |
|---|---|
| APSHAWA BROOK (Macopin)—Entire length | FW2-TP(C1) |
| ... | |
| BEAVER BROOK | |
| (Meriden)—From Splitrock Reservoir Dam downstream to Meriden Road bridge | FW2-TP(C1) |
| (Denville)—Meriden Road Bridge to Rockaway River | FW2-NT |
| TRIBUTARIES | |
| (Meriden)—Two tributaries located approximately three quarters of a mile southwest of Meriden | FW2-TP(C1) |
| BEECH BROOK | |
| (West Milford)—From State line downstream to Monksville Reservoir | FW2-TM |
| ... | |
| BURNT MEADOW BROOK (Green Pond)—Source downstream to confluence with Green Pond Brook | FW2-NT |
| ... | |
| CLINTON BROOK | |
| (W. Milford)—Source to Pequannock River, except Clinton Reservoir listed separately below | FW2-TP(C1) |
| ... | |
| DEN BROOK (Randolph)—Entire length | FW2-NT |
| TRIBUTARY | |
| (Randolph)—Tributary west of Shongum Lake | FW2-TP(C1) |
| ... | |
| GREEN POND BROOK | |
| (Picatinny Arsenal)—Green Pond outlet to, but not including, Picatinny Lake | FW2-TP(C1) |

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| | |
|---|---|
| (Wharton)—Outlet of Picatinny Lake to the confluence with the Rockaway River | FW2-NT |
| ... | |
| HIBERNIA BROOK | |
| (Marcella)—Source to first Green Pond Road bridge downstream of Lake Emma | FW2-TP(C1) |
| (Hibernia)—First Green Pond Road bridge to confluence with Beaver Brook | FW2-TM |
| TRIBUTARY | |
| (Lake Ames)—Source to, but not including, Lake Ames | FW2-TP(C1) |
| ... | |
| INDIAN GROVE BROOK | |
| (Bernardsville)—Entire length | FW2-TP(C1) |
| ... | |
| MONKSVILLE RESERVOIR (Long Pond Iron Works State Park) | FW2-TM(C1) |
| MORSES CREEK—Entire length | FW2-NT/SE3 |
| MOSSMANS BROOK—(West Milford)—Source to confluence with Clinton Reservoir | FW2-TP(C1) |
| ... | |
| OHIO BROOK (Morris Township)—Source downstream to Morristown town line | FW2-TM |
| ... | |
| PASSAIC RIVER | |
| (Mendham)—Source to Interstate 287 bridge, except tributaries described separately below | FW2-TP(C1) |
| (Paterson)—Interstate 287 bridge to Dundee Lake dam | FW2-NT |
| ... | |
| PEQUANNOCK RIVER | |
| MAINSTEM | |
| (Vernon)—Source to confluence with Pacack Brook | FW1(tp) |
| (Hardyston)—Pacack Brook to, but not including, Macopin Reservoir or the tributaries described separately below | FW2-TM |
| (Kinnelon)—Macopin Reservoir outlet to Hamburg Turnpike bridge in Pompton Lakes Borough | FW2-TP(C1) |
| (Riverdale)—Hamburg Turnpike bridge in Pompton Lakes Borough to confluence with Wanaque River | FW2-TM |
| (Pompton Plains)—Confluence with Wanaque River downstream to confluence with Pompton River | FW2-NT |
| ... | |
| POSTS BROOK | |
| (Bloomingdale)—Source to confluence with Wanaque River, except Wanaque Reservoir, and segment described below | FW2-NT |
| (Norvin Green State Forest)—That segment of the stream and all tributaries within the boundaries of Norvin Green State Forest | FW2-NT(C1) |
| ... | |
| ROCKAWAY RIVER | |
| (Wharton)—Source to Washington Pond outlet, excluding the segment within the boundaries of the Berkshire Valley Wildlife Management area | FW2-NT |
| (Berkshire Valley)—That segment within the boundaries of the Berkshire Valley Wildlife Management Area | FW2-NT(C1) |
| (Dover)—Washington Pond outlet downstream to Rt. 46 bridge | FW2-TM(C1) |
| (Boonton)—Rt. 46 bridge to Passaic River, excluding Jersey City Reservoir | FW2-NT |
| ... | |
| WANAQUE RIVER | |
| MAIN STEM | |
| (Wanaque)—Greenwood Lake outlet, through Wanaque Wildlife Management Area and Long Pond Iron Works State Park, including the Monksville Reservoir, to the Monksville Reservoir Dam at Stonetown Road, except tributary described separately below | FW2-TM(C1) |
| (Hewitt)—Entire length of tributary south of Jennings Creek | FW2-TP(C1) |
| (Pompton Lakes)—Wanaque Reservoir dam to confluence with the Pequannock River | FW2-NT |
| ... | |

(f) The surface water classifications in Table 4 are for waters of the Raritan River and Raritan Bay Basin:

TABLE 4

| Waterbody | Classification |
|---|---|
| ... | |
| DRAKES BROOK (Ledgewood)—Source downstream to Hillside Avenue bridge | FW2-TM(C1) |
| (Flanders)—Hillside Avenue bridge to confluence with the South Branch Raritan River | FW2-NT(C1) |
| ... | |
| KRUEGER'S BROOK (Flanders)—Entire length | FW2-TP(C1) |
| ... | |
| ROCKY RUN (Lebanon)—Entire length | FW2-TP(C1) |
| ROUND VALLEY RESERVOIR (Clinton) | FW2-TP |
| ... | |
| TURTLEBACK BROOK (Middle Valley)—Entire length | FW2-NT |
| ... | |

(g) The surface water classifications in Table 5 are for waters of the Wallkill River Basin:

TABLE 5

| Waterbody | Classification |
|---|---|
| ... | |
| FRANKLIN POND CREEK | |
| (Hardyston)—Source to, but not including, Franklin Pond | FW2-TP(C1) |
| (Hamburg Mtn.)—Tributaries within the Hamburg Mtn. Wildlife Management Area | FW2-TM(C1) |
| ... | |
| LIVINGSTON PONDS BROOK (Wawayanda State Park)—Source downstream to State line | FW2-TP(C1) |
| ... | |
| SPARTA GLEN BROOK (Sparta)—Entire length | FW2-TP(C1) |
| ... | |
| WALLKILL RIVER | |
| (Sparta)—Source to confluence with Sparta Glen Brook | FW2-NT |
| (Franklin)—Sparta Glen Brook to Route 23 bridge | FW2-TM |
| (Wantage)—Route 23 bridge to State line | FW2-NT |
| TRIBUTARIES | |
| (Hamburg Mtn.)—The first tributary, just south of Hamburg Mtn., flowing toward the Wallkill River and located entirely within the Hamburg Mtn. Wildlife Management Area | FW1(tm) |
| (Ogdensburg)—Tributary from the outlet of Heaters Pond to the confluence with the Wallkill River | FW2-TP(C1) |
| WANTAGE BROOK (Wantage)—Entire length | FW2-NT |
| WAWAYANDA CREEK | |
| (Vernon)—State line to Pochuck Creek, except unnamed tributary described below | FW2-TM |
| TRIBUTARIES | |
| (Wawayanda)—Source to State Line | FW2-NT |
| (Wawayanda State Park)—Segments within State Park boundaries, except Livingston Ponds Brook as noted above | FW2-TM(C1) |
| WAWAYANDA LAKE (Wawayanda) | FW2-TM(C1) |
| WHITE LAKE (Sparta) | FW2-TM |
| ... | |

(h) FW1 waters are listed in Table 6 by tract within basins:

TABLE 6

| | |
|---|---|
| ... | |
| DELAWARE RIVER BASIN | |
| ... | |
| FLATBROOK-ROY WILDLIFE MANAGEMENT AREA | FLAT BROOK WATERSHED<br>The tributary to Little Flat Brook which orginates north of the Bevans-Layton Rd., downstream to the first pond adjacent to the Fish and Game headquarters building<br>Two tributaries to Flat Brook which originate along Struble Rd. in Stokes State Forest, downstream to the confluence with Flat Brook within Flatbrook-Roy Wildlife Management Area |
| ... | |
| HIGH POINT STATE PARK<br>STOKES STATE FOREST | CLOVE BROOK WATERSHED<br>(No change.)<br>FLAT BROOK WATERSHED<br>All surface waters of the Flat Brook drainage within the boundaries of High Point State Park and Stokes State Forest except the following: |

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(1) Saw Mill Pond and Big Flat Brook downstream to the confluence with Flat Brook;

(2)-(8) (No change.)

(9) Lake Shawanni and its outlet stream to the confluence with Flat Brook;

(10) (No change.)

SHIMERS BROOK WATERSHED

(No change.)

...

(i) (No change.)

---

# (a)

## NEW JERSEY WASTEWATER TREATMENT TRUST

## Sewage Infrastructure Improvement Act Grants Financial Assistance Programs for Wastewater Treatment Facilities

## Adopted Amendments: N.J.A.C. 7:22-9.1, 9.2, 9.4, 9.11, 9.12, 9.13, 9.14, 9.15, 10.1, 10.2, 10.4, 10.5 and 10.6; N.J.A.C. 7:22A-1.4, 1.5, 1.7, 1.12, 1.15, 1.16, 2.4, 2.5, 2.6, 2.8, 3.4, 4.2, 4.5, 4.8, 4.11, 6.1, 6.2, 6.3, 6.4, 6.5, 6.6, 6.7, 6.8, 6.9, 6.11, 6.12, 6.14 and 6.15.

## Adopted New Rules: N.J.A.C. 7:22A-7.

Proposed: April 19, 1993 at 25 N.J.R. 1643(a).

Adopted: July 22, 1993 by Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy, as to N.J.A.C. 7:22-9 and 10 and 7:22A-1, 2, 3, 4, 6 and 7; and July 19, 1993 by the New Jersey Wastewater Treatment Trust, Ellis S. Vieser, Chairman, as to N.J.A.C. 7:22-9.

Filed: July 26, 1993 as R.1993 d.409, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 58:25-23 et seq., 40:55D-93 et seq., 58:10A-1 et seq., 58:11A-1 et seq., 58:11B-1 et seq. and 13:1D-1 et seq.

DEPE Docket Number: 23-93-03.

Effective Date: August 16, 1993.

Expiration Date: December 27, 1996, N.J.A.C. 7:22;
February 5, 1995, N.J.A.C. 7:22A.

The New Jersey Department of Environmental Protection and Energy (the Department) and the New Jersey Wastewater Treatment Trust (the Trust) are adopting amendments to N.J.A.C. 7:22, Financial Assistance Programs for Wastewater Treatment Facilities (previously entitled Construction Grants for Wastewater Treatment Facilities) and N.J.A.C. 7:22A, Sewage Infrastructure Improvement Act Grants. The amendments to these rules and the new rules were proposed on April 19, 1993 at 25 N.J.R. 1643(a). The purpose of the new rules is to implement a component of the New Jersey Sewage Infrastructure Improvement Act, N.J.S.A. 58:25-23 et seq. ("Act") which authorized the Department to provide up to 90 percent grants to affected municipalities in Atlantic, Cape May, Monmouth and Ocean counties for planning and design of projects for the elimination of interconnections/cross-connections of sanitary and stormwater sewer systems. The proposed rules established the Department's program to implement this provision of the Act and also includes related amendments to other components (mapping, monitoring, combined sewer overflow abatement, etc.) of the Act. A public hearing to accept testimony regarding the proposed rules was held on May 21, 1993 in the Large Meeting Room, Ocean County Library, 101 Washington Street, Toms River, New Jersey. Nicholas G. Binder, Administrator of Municipal Wastewater Assistance, served as hearing officer. The comment period on the proposal closed on May 28, 1993. Seven persons made comments regarding the rules at the public hearing. One additional person submitted written comments prior to the close of the comment period. The following is a list of the persons and the entities which they represented who made either written or oral comments on the proposed rules:

1. * Anthony DiLodovico; Schoor, DePalma and Canger Group
2. Lester Jargowsky; Monmouth County Health Department
3. * John Feairheller, Jr., P.E.; Walker, Previti, Holmes and Associates
4. Howard Wooley, Jr.; Long Branch Sewerage Authority
5. * Tom Imholte; Leon S. Avakian Engineers
6. * John Van Dorpe; Maser, Sosinski and Associates
7. * Rose Devaney; Churchill Associates
8. * Alexander Churchill; Churchill Associates

* representing several affected municipalities

The Department and the Trust have given due consideration to all comments received. Concerns and issues raised during the public comment period regarding the proposed new rules and rule amendments have been adequately addressed. Given these circumstances, the Department and the Trust have chosen to proceed with the adoption of the rules with one minor change as noted below.

**Summary** of Public Comments and Agency Responses:

**N.J.A.C. 7:22A-2.4 Grant conditions**

1. COMMENT: One commenter asked why additional requirements are being placed on the interconnection/cross-connection planning grant phase that were not applicable to previous mapping phases and grants. In particular, the requirement to have 10 percent participation by small business concerns owned and controlled by socially and economically disadvantaged individuals was cited as a specific concern. It was suggested that the one percent limitation for administrative costs be increased to account for these additional requirements which the municipality must administer. (7)

RESPONSE: Although the commenter suggests that several additional requirements are being placed on the interconnection/cross-connection grant awards that were not applicable in the mapping phases, the only apparent change is the one cited by the commenter (that is, the requirement to encourage participation by small business concerns owned and controlled by socially and economically disadvantaged individuals (SEDs) found in N.J.A.C. 7:22-9). The 10 percent participation level is a goal and not a requirement. The purpose of this goal-oriented grant condition is two-fold: (1) to promote the use of small business concerns in public contracting for professional services and (2) project sponsors which utilize SEDs during the planning and/or design phases receive credit for such activities when they pursue construction loan funding under the Wastewater Treatment Financing Program. In view of this, the Department believes that this requirement as well as the one percent limit on administrative costs should be retained within the rule.

**N.J.A.C. 7:22A-4.2 Reporting requirements**

2. COMMENT: Several commenters expressed concern regarding the new requirement to submit all sampling data within 10 working days of collecting the sample to the Department. A period of 20 working days from the date of sampling was suggested. One individual asked which office in the Department should the sampling data be submitted. (3,5)

RESPONSE: The Department agrees with the commenters' concerns and has modified the rule to allow the sampling data to be submitted within 20 working days from the date that the municipality receives the data from the laboratory. Further, this time period shall not exceed 40 working days from the date of collection of the sample. All sampling data should be submitted to the DEPE, Land and Water Planning, CN-402, Trenton, NJ 08625.

**N.J.A.C. 7:22A-4.7 Excessive bacterial levels for sample analysis**

3. COMMENT: One commenter expressed satisfaction with the ranking criteria established for second-round planning grants and recommended that the same system be used to determine which outfalls are considered priority outfalls and subject to investigative monitoring and quarterly sampling requirements. It was further suggested that the excessive bacteria levels established in N.J.A.C. 7:22A-4.7 which trigger investigative monitoring are too stringent. (1)

RESPONSE: Over the long term, the Department may consider modifications to the outfall sampling requirements established in the rule. At this time, the requirement to sample all stormwater outfalls on a quarterly basis is mandated by the Act. However, it should be noted that the Department is pursuing amendments to the Act which provide greater flexibility in establishing appropriate sampling requirements. A ranking system similar to the one used for second-round grants may be appropriate at that time. With respect to the investigative monitoring, it is the Department's belief that it is to the affected municipalities' benefit to investigate all outfalls which exceed the standards established in the rule. The bacteria levels which trigger investigative monitoring are based on the surface water classification of the receiving water body

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as set forth in the Surface Water Quality Standards. These investigations not only yield important baseline information regarding interconnections/cross-connections for each outfall and stormwater drainage system, but are valuable in identifying any nonpoint source pollution problem.

**N.J.A.C. 7:22A-7.1 Applicability**

4. COMMENT: One commenter requested clarification as to whether authorities are eligible for the interconnection/cross-connection funding under the Act. Several commenters requested guidance from the Department regarding situations where the authority owns/operates the sanitary sewer system and the municipality owns/operates the stormwater sewer system, especially in situations where the municipality determines that interconnection/cross-connection abatement measures will require modifications to the sanitary system. (3,6)

RESPONSE: The Act authorizes the Department to provide grants to municipalities with a stormwater sewer system discharging directly into the salt waters of Monmouth, Ocean, Atlantic and Cape May counties (that is, an affected municipality as defined in N.J.A.C. 7:22A-1.4) for the planning or design of interconnection/cross-connection abatement facilities. It does not authorize the grants in this subchapter to be made to sewerage or utilities authorities or other governmental units. The Department recognizes that the investigative monitoring and sampling activities may result in situations where the cost-effective alternative to abate the interconnection/cross-connection is to repair or replace sanitary sewer lines, manholes or other wastewater treatment facilities. In instances where two or more entities own/operate the sanitary and stormwater systems in a municipality, the Department encourages the affected municipality to consult with the other governmental entities to coordinate activities and incorporate the concerns of all owners and operators of stormwater/sanitary sewer systems in the municipality in the scope of work early in the planning stages and arrange for intergovernmental agreements which define the roles and responsibilities of each entity. With respect to the actual construction loan, the bond acts and other sources from which the funding is derived do permit awards to be made to municipalities as well as to other local government units (including sewerage or utilities authorities).

**N.J.A.C. 7:22A-7.4 Initial planning grants**

5. COMMENT: One commenter expressed concern that the June 15, 1993 application date was too soon since the rules would not be adopted. Several other commenters agreed and noted that several of the affected municipalities have just begun investigative monitoring activities and have not fully identified the nature of their interconnection/cross-connection needs (a process which could take up to three years under the final mapping grant agreement). Concern was expressed that the slower municipalities would lose out on their opportunity for an initial planning grant. It was also suggested that the Department hold group pre-application meetings to speed up the process. (1,5,7)

RESPONSE: The June 15, 1993 date is not a deadline for initial planning grant applications and does not affect a project's rank or the funds allotted to an affected municipality. June 15, 1993 is the date on which the Department will begin accepting initial planning grant applications. The deadline for the submission of a complete planning grant application is December 15, 1993 which allows time for the towns to evaluate their stormwater/sanitary sewer systems during the peak summer season, particularly for the top priority outfalls located within their municipal boundaries. For those towns which have not identified a specific interconnection/cross-connection need over the next several months, they may request an extension to the December 15, 1993 deadline as provided for in N.J.A.C. 7:22A-7.4(b). Since the Department anticipates that sufficient funds will be available to award an initial planning grant to all affected municipalities with an interconnection/cross-connection abatement need, initial planning grant award offers may be made upon the Department's certification of an affected muncipality's initial planning grant application. To expedite the application process, group pre-application conferences may be arranged with the Municipal Wastewater Assistance program, if desired by the project sponsors.

**N.J.A.C. 7:22A-7.8 Application procedures**

6. COMMENT: One commenter requested clarification as to what activities would be eligible under an initial planning grant to abate interconnections/cross-connections and specifically inquired whether the planning grant could be used for investigative activities associated with locating specific interconnections/cross-connections. (1)

RESPONSE: The Department anticipates that the following activities will generally be eligible under an initial planning grant: the development of a report which describes the existing wastewater and stormwater treatment systems and their relationship to the proposed project, the studies necessary to determine the cost-effective, environmentally sound and implementable alternative to eliminate the interconnection or abate the cross-connection, the development of a program to encourage participation from small business concerns owned and controlled by socially and economically disadvantaged individuals, the evaluation of several alternatives including an assessment of the environmental and cultural resource impacts of each alternative considered to address the problem and, for the selected alternative, relevant design parameters, hydraulic profiles, estimated construction costs and operation and maintenance costs, cost impacts on system users, needed mitigating measures and proposed institutional/managerial arrangements necessary to implement the project. In general, the planning grants are not intended to be used to perform activities which the affected municipality is required to complete in accordance with their final mapping grant agreement. Among these requirements, is the submission of a final map which identifies all interconnections/cross-connections within the geographical boundaries of the municipality. Further, the affected municipality must identify an interconnection/cross-connection prior to the submittal of a planning grant application. Thus, an affected municipality cannot use planning grant funds to undertake investigative monitoring activities which are required under a final mapping grant agreement.

**Sewage Infrastructure Improvement Act Implementation/Funding**

7. COMMENT: One commenter requested information regarding the relationship of the Sewage Infrastructure Improvement Act and the Stormwater Management and Combined Sewer Overflow Abatement Bond Act of 1989. Another commenter strongly recommended that the $50 million from the 1989 Bond Act be made available immediately as construction grants and loans for municipalities with stormwater problems ranging from cross-connections and interconnections to contamination by outside sources other than sanitary sewers which would require corrective measures to prevent future pollution. This commenter further suggested that the 1989 Bond Act would be more effectively administered if the funds were deposited in a "Stormwater Pollution Fund" rather than in the "Wastewater Treatment Fund." (7,8)

RESPONSE: The Sewage Infrastructure Improvement Act provides grants to local government units for the planning and design associated with combined sewer overflow (CSO) abatement and interconnection/cross-connection elimination/abatement projects. The Infrastructure Act does not authorize funding to construct the improvements to the systems. The 1989 Bond Act funds are expected to be used for the construction of those projects planned and designed under the Infrastructure Act.

The Federal Fiscal Year 1994 Priority System proposal issued in February 1993 allotted $5 million under the Wastewater Treatment Financing Program for interconnection/cross-connection abatement project loans in the FFY94/SFY95 funding cycle. Four projects are currently eligible for a construction loan. The types of projects which qualify as interconnection/cross-connection abatement facilities are not limited to direct sanitary and stormwater sewer line connections, but also include a variety of indirect pollution problems resulting from such systems such as overflows from sanitary manholes which flow into storm drains during rain events. A future program to be implemented under the Infrastructure Act will address nonpoint source pollution concerns, including contamination from sources other than a sanitary/stormwater system interrelationship. The Department has chosen to provide financial assistance in the form of loans rather than grants utilizing 1989 Bond Act funds in order to provide a financing program that will be able to address future CSO and interconnection/cross-connection abatement needs. The New Jersey Wastewater Treatment Trust is sponsoring amendments to the 1989 Bond Act which will allow the Trust to leverage a portion of those funds and to make loans under the same financial structure as the existing Wastewater Treatment Financing Program, which is supported by the Department. Funds from the 1989 Bond Act have not been obligated since many of the eligible projects are still in the planning or pre-planning stages.

The 1989 Bond Funds were not deposited in the "Wastewater Treatment Fund" as the commenter suggested. Although the program structure is similar to the Wastewater Treatment Financing Program, the 1989 Bond Act funds have been and are legislatively required to be deposited into the "Stormwater Management and Combined Sewer Overflow Abatement Assistance Fund." Further, financial assistance awards made using these funds are subject to the statutory requirements of the 1989 Bond Act.

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8. COMMENT: One individual commented that adequate funds have not been allocated for the affected municipalities to accomplish the work required by the Sewage Infrastructure Improvement Act and, in particular, for the mapping and investigative monitoring necessary to identify interconnections/cross-connections and for the long-term quarterly sampling of stormwater outfalls. Although generally pleased that the Department is moving forward with the Act's implementation, it was suggested that the Department allocate more funds for the final mapping and monitoring aspects before proceeding with the interconnection/cross-connection grant aspects of the Act. (1)

RESPONSE: The Sewage Infrastructure Improvement Act established a number of requirements on municipalities and other public entities to address both point and nonpoint sources of pollution which discharge from stormwater sewer systems and combined sewer overflow points. In order to maximize use of the $33.5 million available under the Act to address these significant pollution problems, the Department allocated specific dollar amounts for each activity: for planning and design for combined sewer overflow (CSO) abatement facilities Statewide ($17.4 million) and for stormwater mapping ($6.6 million), interconnection/cross-connection planning and design ($4.7 million) and nonpoint source planning ($2.8 million) for the affected municipalities in the four southern coastal counties. An additional $2.0 million was used for the Operation Clean Shores program from the Act. In allocating the limited financial resources, the Department recognized that certain activities required to be performed by local government units affected by the Act may not be fully funded. Although the mapping grants provide funds for investigative monitoring activities, one such activity for which the Department is not providing funds to affected municipalities is the quarterly monitoring of stormwater outfalls required by the Act. The quarterly monitoring activity is mandated by the Act, is a long-term requirement and is considered an on-going, routine inspection function which is generally not reimburseable under the State's financing programs. With respect to the investigative monitoring necessary to identify interconnections/cross-connections, the final mapping grant awards were intended to provide the affected municipalities with funds to complete this and other mapping-related tasks. Although the Department would ideally like to fund all costs related to the activities under the Act, the Department has adopted certain management policies in the program rules in order to extend the limited funds available under the Act to a larger number of projects and programs contemplated by the Act. The Department does not believe that it would be appropriate to delay the implementation of the interconnection/cross-connection planning and design grant aspects or reallocate funds in order to provide additional funds to affected municipalities for the final mapping activities. The Department believes it is best to maintain the impetus of the Act's implementation and proceed with the award of planning and design grants to abate interconnections/cross-connections. It is generally recognized that those affected municipalities which are finalizing their mapping/investigative monitoring activities will be in a better position to prepare a scope of work for planning and submit a complete planning grant application in a timely manner. Alternatively, for those municipalities which have not aggressively identified interconnections/cross-connections as part of their mapping efforts, the Department has provided a mechanism through which an extension request may be submitted prior to the December 15, 1993 deadline for planning grant applications under the rule.

In addition, the Department is pursuing amendments to the Act which would reduce the financial burden on the affected municipalities associated with the Act's quarterly monitoring requirement. The Department supports reducing the quarterly monitoring requirements for outfalls that discharge to salt waters to sampling of priority outfalls twice a year and all other outfalls once a year.

9. COMMENT: One individual suggested that the Department allow a project which receives a construction loan (which generally includes an allowance for planning and design activities) under the Wastewater Treatment Financing Program to also be eligible to receive a planning and/or design grant under the Act and to use the grant money to repay the construction loan. (1)

RESPONSE: Projects which qualify for a construction loan under the Wastewater Treatment Financing Program are also eligible to receive reimbursement from the interconnection/cross-connection planning grant program provided the project sponsor receives authorization to award the contract for planning activities from Municipal Wastewater Assistance prior to the award of the contract and the project sponsor foregoes its right to a loan allowance for such planning activities under the Wastewater Treatment Financing Program. The first condition is intended to assure that the scope of planning work is adequate to satisfy the Departmental planning requirements. The second condition serves to prevent State funds from being tied up that could otherwise be used to provide funds for other projects. While it may appear that projects which move forward under the construction loan program to correct their sewer problems are penalized, the municipalities in which the projects are constructed reduce the potential for ocean and bay beach closures and other environmental impacts due to sewer systems which malfunction. A malfunctioning system in a shore community can generate significant negative environmental, social and economic impacts and it may be more appropriate for a municipality to forego its planning and design grant and pursue a construction loan in order to correct the known pollution problems without delay. Further, such project sponsors, in addition to being eligible for an allowance based on the building costs to assist in defraying the costs of planning and design activities, may benefit through reduced inflation impacts, current favorable interest rates as well as the assurance that sufficient construction funding is currently available.

10. COMMENT: One commenter expressed general displeasure with the progress of the Sewage Infrastructure Improvement Act. He cited several examples of the massive infrastructure problems in the shore communities and submitted reports and presented a video to support his concerns. It was suggested that the program be flexible to fund major sewer rehabilitation work. It was also noted that, due to the major winter storms in 1992, recurring earthquakes and extraordinarily high tides, the municipalities do not have sufficient funds to construct the infrastructure improvements necessary to protect coastal waters, back bays and estuaries. In addition, concern was expressed that the construction loan program does not accommodate emergency situations, that the two year time frame is too long and the program requirements are cumbersome. It was suggested that the program requirements be streamlined and the disbursement of funds in emergency situations be expedited. (2,4)

RESPONSE: Due to the complexity of the Sewage Infrastructure Improvement Act, the Department chose to implement the provisions in the Act in a phased approach through which each phase links together with the activities performed by a municipality in the previous phase. Although the Act only authorizes the Department to finance the planning and design (not construction) of the projects necessary to protect the State's waters, the Wastewater Treatment Financing Program (a low-interest loan program) provides financial assistance to local government units for the construction of such infrastructure improvements, including major sewer rehabilitation work. The two year time frame to which the commenter referred was the average time frame for a typical wastewater treatment facilities project to qualify for the construction loan. Sewer rehabilitation projects and other small projects are generally able to complete the requirements faster (possibly within a nine to 12 month time frame) and may qualify the project for preaward approval which allows construction to begin prior to loan execution. Although the construction loan program rule includes provisions which allow the Department and the Trust to grant preaward approval for emergency situations, the time frame for preaward approvals (even under a best case scenario) will likely range from three to six months since certain program requirements (including the requirement to prepare and issue an environmental assessment in accordance with N.J.A.C. 7:22-10) must be satisfied before the actual construction of the project can begin. The environmental assessment requirement as well as various other program requirements are mandated by Federal statutes from which a portion of the monies to provide loans to the projects is derived. Given these restraints, it is recognized that certain emergency situations are best handled at the local level. Finally, it should also be noted that the $5 million allocated for the construction of interconnection/cross-connection projects under the FFY94 Priority System excludes projects which qualify as wastewater treatment facilities (that is, sanitary sewer rehabilitation projects are exempt from the $5 million cap).

11. COMMENT: One commenter noted that his experience with the construction loan program was not pleasant and the rules (namely N.J.A.C. 7:22) were complex and inflexible. Of a system consisting of 120 miles of sewer lines, the project sponsor chose to limit the scope of the rehabilitation project to 12 miles of sewer lines solely for economic reasons. After loan award and the receipt of bids for the project (which were lower than the initial project estimate), it was determined that additional rehabilitation work was now within its economic limit. However, the Department and the Trust determined that the additional rehabilitation work was not within the scope of the project description

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included in the loan agreements. The commenter concluded by stating that he felt that the rules served as an impediment to achieving the goals of the program and to improving the environment. (4)

RESPONSE: Although the circumstances described above do not directly relate to the rule proposal, it is anticipated that many of the projects which receive the interconnection/cross-connection planning and design grants will also pursue a construction loan. The scope of the project for which funding under a construction loan is provided is included in a project description in the loan agreements. Prior to loan award, the Department certifies that the project (as described in the loan agreement) is in compliance with all applicable rules and requirements. After loan award, any additional rehabilitation work is considered a new project and must receive separate certification since it impacts other areas of the service district not initially considered in the project scope and not initially reviewed for compliance with applicable rules and requirements. It should be noted, though, that these additional scopes of work can generally be fast-tracked through the loan program and could qualify for preaward approval. Thus, the project sponsor can move to construction in an expedited manner while retaining eligibility for its loan in a subsequent funding cycle.

**Permitting Concerns**

12. COMMENT: One commenter expressed concern and cited examples of infrastructure projects which were needlessly delayed due to the Department's permitting process, especially Coastal Area Facilities Review Act (CAFRA) permits and Treatment Works Approval (TWA) permits. It was suggested that the TWA permits could be issued by the Department contingent upon the receipt of a CAFRA permit. (3)

RESPONSE: The Department has undergone a reorganization which centralized the permitting process in the Environmental Regulation group. In addition, the Office of Permit Information and Assistance was created to help permit applicants with the various procedures and requirements. With the permitting functions under one group, the Department expects delays in the permit processes to be minimized in the future. It was also noted that the TWA rules are in the process of being revised, and the Department suggested that the commenter pursue this issue during the public participation process that will be conducted for the TWA rule amendments in the near future.

**Summary** of Hearing Officer's Recommendations and Agency Response:

Administrator Binder recommended that the Department adopt the proposed amendments and proposed new rule with minor revisions as discussed above in the Summary of Public Comments and Agency Responses. The Department agrees with the recommendations.

Administrator Binder's recommendations are set forth in more detail in the hearing officer's report. A copy of the record of the public hearing which includes the hearing officer's report is available upon payment of the Department's normal charges for copying. Persons requesting copies should contact:

Janis E. Hoagland, Esq.
Department of Environmental Protection
and Energy
Office of Legal Affairs
CN 402
Trenton, NJ 08625

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

7:22-9.1 Scope and purpose

(a) This subchapter establishes procedures for providing opportunities for socially and economically disadvantaged ("SED") contractors and vendors to supply materials and services under State financed construction contracts for wastewater treatment facilities. To implement the policies established in N.J.S.A. 58:11B-26, N.J.S.A. 40:11A-41 et seq., and N.J.S.A. 52:32-17 et seq., this subchapter applies to wastewater treatment projects receiving financial assistance from the New Jersey Department of Environmental Protection and Energy and the New Jersey Wastewater Treatment Trust pursuant to N.J.A.C. 7:22-3, 7:22-4, 7:22-6, 7:22A-6 and 7:22A-7. Under the provisions of N.J.A.C. 7:22-3, 7:22-4, 7:22-6, 7:22A-6 and 7:22A-7, the Department and the Trust require recipients of Trust and Fund loans and other assistance to establish such programs for socially and economically disadvantaged small business concerns, to designate a public agency compliance officer, and to submit to the Department and Trust procurement plans for implementing the SED program. In ddition, N.J.A.C. 7:22-3.17(a)24, 4.17(a)24, 6.17(a)24 and 7:22A-2.4(a) provide that a goal of not less than 10 percent of the total amount of all contracts for building, materials and equipment, or services for a construction project must be awarded to small business concerns owned and controlled by one or more socially and economically disadvantaged individuals. Where a local government unit has a SED participation goal which exceeds 10 percent of the total amount of all contracts, the local government unit must comply with both the Department's rules and the local set-aside ordinance.

(b) (No change.)

7:22-9.2 Defintions

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

. . .

"New Jersey wastewater treatment financing program" means financing provided to local government units pursuant to N.J.A.C. 7:22-3, 4 and 6, and 7:22A-6 and 7.

. . .

"Public agency compliance officer" means an officer or employee of the local government unit, who may be an existing officer or employee, who is designated by the local government unit to monitor and enforce compliance with the affirmative action and SED requirements of the applicable program rules and this subchapter.

. . .

7:22-9.4 Requirement to develop SED Utilization Plan

(a) Each local government unit shall develop, in consultation with the Office, a plan for achieving its SED utilization requirements (the "project plan"). Development of a plan shall be completed before the Department and, when relevant, the Trust may approve an application pursuant to the applicable program rules.

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

(d) If the contractor does not comply with the requirements of the contractor's plan and the local government unit does not take steps to otherwise comply with N.J.A.C. 7:22-9.3(a), the Department and, in the case of a Trust loan, the Trust, may take any of the actions or combinations thereof specified in N.J.A.C. 7:22-3.40 through 3.44, 7:22-4.40 through 4.44, 7:22-6.40 through 6.44 and 7:22A-1.8 through 1.13.

(e) (No change.)

7:22-9.11 Public agency compliance officer

(a) (No change.)

(b) The public agency compliance officer shall be responsible for coordinating SED utilization efforts on the project and for monitoring and enforcing compliance with the affirmative action and SED requirements of the applicable program rules.

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

7:22-9.12 Reports

(a)-(f) (No change.)

(g) Failure to comply with the reporting requirements of (a) through (d) and (f) above may subject the local government unit to the remedies for noncompliance with State and Trust loan or grant conditions specified in the applicable program rules.

7:22-9.13 Assessment of compliance

(a) Where the Office determines that a local government unit has failed or is failing to meet the 10 percent SED utilization requirement, the local government unit shall, upon the written request of the Office, submit the following:

1.-7. (No change.)

8. Proof that the assistance of State Agencies was solicited, including:

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Office of Equal Opportunity and Public Contract Assistance
New Jersey Department of Environmental Protection and Energy
440 East State Street
Trenton, New Jersey 08625
Division for the Development of Small Businesses and Women Businesses and Minority Businesses
New Jersey Department of Commerce and Economic Development
CN-835
1 West State Street
Trenton, New Jersey 08625

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

7:22-9.14 Penalties

Whenever a local government unit or a contractor has failed to comply with the requirements of this subchapter, including the 10 percent requirement for SED utilization, the Department, or the Department and the Trust, in the case of a Trust loan recipient, may withhold all of the loan or grant money, or a portion thereof, and may take any of the other actions or combinations thereof specified in N.J.A.C. 7:22-3.40 through 3.44, 7:22-4.40 through 4.44, 7:22-6.40 through 6.44 and 7:22A-1.8 through 1.13 which are remedies for noncompliance with any of the conditions of a loan or grant.

7:22-9.15 Administrative hearings

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

7:22-10.1 Scope and construction

(a) This subchapter constitutes the rules of the New Jersey Department of Environmental Protection and Energy regarding the environmental assessment requirements for projects receiving financial assistance pursuant to N.J.A.C. 7:22-3, 4 and 6 and N.J.A.C. 7:22A-6 and 7.

(b) (No change.)

(c) This subchapter is promulgated for the following purposes:

1. (No change.)

2. To establish environmental assessment requirements which must be complied with in order to receive financial assistance provided pursuant to N.J.A.C. 7:22-3, 4 and 6, and N.J.A.C. 7:22A-6 and 7;

3.-4. (No change.)

7:22-10.2 Definitions

Unless otherwise specified, the terms used herein will have the same meanings as those terms are defined in N.J.A.C. 7:22-3, 4 and 6 and N.J.A.C. 7:22A-1. Additional definitions are as follows:

...

7:22-10.4 Level 1 environmental review

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

(d) The Department will review the environmental planning document submitted by the local government unit and will make one of the following determinations:

1. The Level 1 environmental planning document is complete, acceptable, and verifies the preliminary determination to proceed with this level of environmental review. In this case, the Department will prepare and issue a Level 1 decision statement as set forth in (e) below which will be sent to a project mailing list developed in accordance with N.J.A.C. 7:22-10.10(c). The local government unit shall publish a notice in a newspaper of general circulation in the planning area within two weeks of the date of the Department's decision statement. The notice must describe the proposed action, indicate the decision by the Department to approve the project, and advise the public that the local government unit shall, upon written request, make available for public review both the planning documents and the Department's decision statement. Upon issuance of the decision statement, planning is approved and the Department may proceed with award of a loan, subject to the provisions of (e) below, and provided the other requirements of the program have been met as specified in the applicable program rules.

2.-3. (No change.)

(e)-(f) (No change.)

7:22-10.5 Level 2 environmental review

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

(d) When appropriate, in accordance with (c)1 above, the Department will prepare and issue a preliminary Level 2 decision statement and environmental appraisal to the mailing list developed for the project in accordance with N.J.A.C. 7:22-10.10(c). The Department will take no further administrative action until after the conclusion of a 30-day comment period on the decision statement. If no significant adverse comment is received at that point, the Department will approve the planning and may proceed with an offer of loan assistance, provided the other requirements of the program, as set forth in the applicable program rules have been met.

(e) (No change.)

7:22-10.6 Level 3 environmental review

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

(c) If a Level 3 environmental review is required by the Department prior to completion of a Level 2 environmental information document, then an environmental information document must be prepared in accordance with N.J.A.C. 7:22-10.5(b). In addition, an environmental impact statement must be prepared under a Level 3 environmental review. Environmental impact statements shall be prepared by the local government unit. The Department must approve the scope, content and conclusion of both draft and final environmental impact statements prior to publication. The procedure will be as follows:

1.-9. (No change.)

10. After the conclusion of the comment period for the final environmental impact statement, the Department will prepare a Level 3 decision statement which will respond to comments received on the final environmental impact statement, set forth the decision made by the Department, and the basis for the decision. No administrative action will be taken by the Department prior to the conclusion of a 30-day comment period for the decision statement. If no further significant adverse comment is received during the comment period for the decision statement, the Department will approve the planning and the Department may proceed with an offer of assistance, provided other program requirements as set forth in the applicable program rules have been met. If adverse comment is received which was not adequately addressed in the environmental impact statement process, the Department may require a supplemental evaluation and decision statement or may determine not to participate in the proposed project.

(d)-(e) (No change.)

7:22A-1.4 Definitions

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

...

"Combined sewer system" means a sewer system that is designed to carry sanitary sewage at all times and that is also designed to collect and transport stormwater from streets and other sources, thus serving a combined purpose.

...

"Combined Sewer Overflow Account" means the component of the Municipal Stormwater Management and Combined Sewer Overflow Abatement Assistance Fund as determined by the Department which will be used to provide grants to local government units for the planning and design of combined sewer overflow abatement facilities.

...

"Department" means the New Jersey Department of Environmental Protection and Energy and its successors and assigns.

...

"Interconnection/cross-connection abatement facilities" includes, but is not limited to, any equipment, plants, structures, machinery, or apparatus, or any combination thereof, acquired, used, con-

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structed or operated by, or on behalf of, an affected municipality for storage, collection, reduction, recycling, disinfection, reclamation, disposal, separation or other treatment essential to the abatement of interconnections and/or cross-connections.

"Interconnection/Cross-Connection Abatement Account" means the component of the Municipal Stormwater Management and Combined Sewer Overflow Abatement Assistance Fund as determined by the Department which will be used to provide grants to affected municipalities for the planning or design of interconnection/cross-connection abatement facilities.

. . .

7:22A-1.5 Fund procedures

(a) The moneys appropriated pursuant to the Act and any interest earned thereon shall be deposited in a separate interest bearing account known as the Municipal Stormwater Management and Combined Sewer Overflow Abatement Assistance Fund.

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

7:22A-1.7 Enforcement

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

(c) In order to implement this chapter, all affected municipalities shall ensure that they have access to stormwater and sanitary sewer systems that are not municipally owned and operated. Affected municipalities may ensure such access by adopting an ordinance in accordance with N.J.S.A. 40:48-2; by adopting an ordinance, through their local board of health, in accordance with N.J.S.A. 26:3-33 or 3-64; by entering into agreements with private parties; or by other means that provide municipal access.

7:22A-1.12 Termination of the grant agreement

(a) (No change.)

(b) Termination of the grant agreement by the recipient shall be conducted as follows:

1. A recipient shall not unilaterally terminate the project work for which grant moneys have been awarded except for good cause and subject to negotiation and payment of appropriate termination settlement costs. The recipient shall promptly give written notice to the Department of any complete or partial termination of the project work by the recipient or intent thereof, The term "good cause" shall include, but not be limited to, circumstances beyond the control of the recipient such as fire, flood, riot or strike.

2.-3. (No change.)

(c)-(e) (No change.)

7:22A-1.15 Debarment

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

(d) Any person included on the State Treasurer's list as a result of action by a State agency, who is or may become a bidder on any subagreement which is or shall be funded from the Fund under this chapter, may present information to the Department why this section should not apply to such a person. If the Department determines that it is essential to the public interest and files a finding thereof with the New Jersey Attorney General, the Department may grant an exception from the application of this section with respect to a particular contractor in keeping with N.J.A.C. 7:1-5.9. In the alternative, the Department may suspend or debar any such person, or take such action as may be appropriate, pursuant to N.J.A.C. 7:1-5.

7:22A-1.16 Administrative hearings

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

(d) During the pendency of the review and hearing, the challenged Department decision or action shall remain in full force and effect, unless a stay has been requested in writing and granted by the Department.

(e)-(f) (No change.)

7:22A-2.4 Grant conditions

(a) The following requirements, as well as such statutes, rules, terms and conditions which may be applicable, are conditions of each grant, and conditions to each disbursement under the grant agreement:

1.-2. (No change.)

3. The recipient of grants for combined sewer overflow and interconnection/cross-connection abatement projects shall comply with the rules entitled Awarding Contracts for State Assisted Projects to Small Business Concerns Owned and Controlled by Socially and Economically Disadvantaged Individuals, N.J.A.C. 7:22-9;

4.-7. (No change.)

8. An amount of any grant disbursement equal to 100 percent of any unpaid portion of a finally determined State assessed civil administrative penalty pursuant to N.J.A.C. 7:14-8 shall be withheld until said penalty is paid in full;

9.-14. (No change.)

15. The recipient shall comply with the Department's standards of conduct (N.J.A.C. 7:22-8) governing public bodies or utilities created pursuant to New Jersey law to treat wastewater within the territorial boundaries of a service area and the Local Government Ethics Law (P.L. 1991, c.29; N.J.S.A. 40A:9-22);

16. The recipient shall comply with the Environmental Assessment Requirements for State Assisted Wastewater Treatment Facilities (N.J.A.C. 7:22-10);

17. (No change.)

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

(d) Recipients shall include the following statement in each subagreement awarded pursuant to this chapter:

"This contract or subcontract is or may be funded in part with funds from the New Jersey Department of Environmental Protection and Energy. Neither the State of New Jersey nor any of its departments, agencies, or employees is, or will be, a party to this contract or subcontract or any lower tier contract or subcontract. This contract or subcontract is subject to the requirements contained in N.J.A.C. 7:22A."

(e) (No change.)

7:22A-2.5 Project changes and modifications to grant agreements

(a) (No change.)

(b) The recipient shall promptly notify the Department in writing (certified mail, return receipt requested) of events or proposed changes which may require modifications, including, but not limited to:

1.-6. (No change.)

(c) If the Department decides an amendment is necessary, the recipient shall be notified and a grant amendment shall be processed in accordance with N.J.A.C. 7:22A-2.6. If the Department decides a grant amendment is not necessary, it shall follow the procedures of N.J.A.C. 7:22A-2.7 or 2.8, as applicable.

7:22A-2.6 Grant amendments

(a) The Department shall require a grant amendment to change principal provisions of a grant agreement where project changes substantially alter the objective or scope of the project or time of performance of the project or any major phase thereof.

(b) The State and recipient shall effect a grant amendment only by a written amendment to the grant agreement executed by the State and the recipient.

7:22A-2.8 Other changes

All other project changes, which do not require a grant amendment as stated in N.J.A.C. 7:22A-2.6, shall be undertaken only upon written approval of the Department.

7:22A-3.4 Pre-application procedures

Applicants may request a pre-application conference to discuss application procedures, prior to submission of a grant application. This conference is not part of the application procedures and verbal statements made during the conference shall not bind the Department.

7:22A-4.2 Reporting requirements

(a) On or before June 17, 1992 or within one year from the date of execution of the final mapping grant agreement, whichever comes later, all affected municipalities shall submit a copy of the final map, adopted by the governing body of the affected municipality and prepared in accordance with N.J.A.C. 7:22A-4.3, to the Department. The affected municipality shall submit any other submittals required by N.J.A.C. 7:22A-4.3 at the time of submittal of the final map.

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(b) Within 12 months of the submittal of the final map in (a) above and yearly thereafter, all affected municipalities shall submit updated portions of the final map in accordance with N.J.A.C. 7:22A-4.3(g), to the Department.

(c) On or before October 17, 1991, all affected municipalities which did not receive a grant for preliminary mapping shall submit the information required under N.J.A.C. 7:22A-3.10 and 3.11 to the Department.

(d) On or before October 17, 1991, all affected municipalities shall submit an investigative priority list in accordance with N.J.A.C. 7:22A-4.4 to the Department.

(e) All affected municipalities shall submit a copy of the sampling data collected in accordance with N.J.A.C. 7:22A-4.5 to the Department within *[10]* ***20 working days from the date that the municipality receives the data from the laboratory. In no case shall this time period exceed 40*** working days *[of]* ***from the date of*** collection ***of the sample***.

(f) At any time prior to, but no later than one month after, the adoption of the final map in (a) above, all affected municipalities shall submit a priority list for quarterly monitoring in accordance with N.J.A.C. 7:22A-4.8(b) to the Department.

(g) All affected municipalities shall submit a copy of the quarterly monitoring data collected in accordance with N.J.A.C. 7:22A-4.8 to the Department within *[10]* ***20 working days from the date that the municipality receives the data from the laboratory. In no case shall this time period exceed 40*** working days *[of]* ***from the date of*** collection ***of the sample***. The submission shall note where sample analysis indicates that there are excessive levels of bacteria, as specified in N.J.A.C. 7:22A-4.7.

(h) All affected municipalities shall submit a quality assurance program plan and have the plan approved by the Department, in accordance with N.J.A.C. 7:22A-4.6(a), prior to taking any grab samples as required by N.J.A.C. 7:22A-4.5 and 4.8. The affected municipalities shall include the project specific information and submit the completed quality assurance program plan to the Department.

(i) All affected municipalities shall submit to the Department a notice of any interconnection and/or cross-connection that is found within 24 hours of the finding thereof. The notice shall include the location of the interconnection or cross-connection and the owner and operator of the system where the interconnection or cross-connection is found.

7:22A-4.5 Identification of interconnections and cross-connections

(a) (No change.)

(b) Prior to the submission of the final map in accordance with N.J.A.C. 7:22A-4.3, all affected municipalities shall investigate at least one-third of the stormwater outfalls in accordance with (c) and (d) below. The affected municipality shall investigate the remaining stormwater outfalls by June 17, 1994 or within three years of the date of the execution of the final mapping grant agreement, whichever comes later.

(c)-(e) (No change.)

7:22A-4.8 Quarterly monitoring

(a) All affected municipalities shall initiate the quarterly monitoring of their stormwater outfall lines in the first month following the submittal of the final map. The affected municipality shall, on a quarterly basis, take a grab sample at all stormwater outfalls for any stormwater sewer system discharging into salt water in accordance with N.J.A.C. 7:22A-4.6(d)1.

(b)-(h) (No change.)

7:22A-4.11 Pre-application meeting

Prior to submission of a grant application, applicants may request a pre-application conference to discuss application procedures. This conference is not part of the application procedures and verbal statements made during the conference shall not bind the Department.

SUBCHAPTER 6. COMBINED SEWER OVERFLOW ACCOUNT PROCEDURES AND REQUIREMENTS

7:22A-6.1 Applicability

This subchapter constitutes the rules of the Department governing the award of grants pursuant to the Act to local government units for the planning and design of dry weather overflow elimination and solid/floatables reduction at combined sewer overflow points throughout the state. These rules prescribe the procedures for the award of grants from the Combined Sewer Overflow Account.

7:22A-6.2 Combined Sewer Overflow Account

(a) The moneys in the Combined Sewer Overflow Account are available for the planning and design of dry weather overflow elimination and solid/floatables reduction at combined sewer overflow points pursuant to the provisions of this subchapter.

(b) Any local government unit authorized to control or operate a combined sewer system shall be eligible to receive grant moneys from the Combined Sewer Overflow Account. Grant moneys shall be provided to the extent available to local government units for the planning and design of dry weather overflow elimination and solids/floatables reduction at combined sewer overflow points based on the points awarded to the project in accordance with the Priority System ranking criteria and the submittal of the complete application within the prescribed time frames. As a component of the proposed Priority System, the Department may establish application deadlines for applicable funding cycles and a deadline by which new applications for planning and design grants for dry weather overflow elimination and solids/floatables reduction shall no longer be accepted or acted upon. Any remaining moneys in the Combined Sewer Overflow Account would be available for other authorized purposes under the Act.

(c) The consideration for a grant award from the Combined Sewer Overflow Account shall not be used as a defense by the local government unit to any action by any agency for the local government unit's failure to comply with the Act or to obtain and comply with all requisite permits, licenses and operating certificates.

7:22A-6.3 Terms of financial assistance from the Combined Sewer Overflow Account

(a) The Department may offer grants from the Combined Sewer Overflow Account for up to 90 percent of the allowable costs for the planning and/or design of combined sewer overflow abatement facilities.

(b) Moneys will be disbursed to recipients, upon request, as work progresses and expenses are incurred and approved by the Department unless otherwise restricted by N.J.A.C. 7:22A-6.11 or unless otherwise indicated in the grant agreement. Local government units shall submit vouchers and other documentation as may be required by the Department in support of their request for disbursement of funds.

(c) (No change.)

7:22A-6.4 Criteria for project priority

(a) Each year, the Department shall develop a Priority System, Intended Use Plan and Project Priority List for the forthcoming federal Fiscal Year. The Priority System shall provide the ranking methodology which evaluates wastewater treatment facilities (including combined sewer overflow abatement facilities) individually for their anticipated impacts on existing and potential water uses in combination with present water quality conditions.

(b) (No change.)

(c) Only those local government units committing to the project document submittal or application deadlines shall have their project considered for financial assistance in the forthcoming funding cycle.

7:22A-6.5 State and Federal funding

Local government units which receive grants from the Combined Sewer Overflow Account shall be ineligible to receive financial assistance for the same scope of work (planning or design) for the project in the form of a federal grant, State Matching Funds pursuant to 7:22-2, a Wastewater Treatment Fund or New Jersey Wastewater Treatment Trust loan pursuant to N.J.A.C. 7:22-3 and 4, or a

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Pinelands Infrastructure Trust grant or loan pursuant to N.J.A.C. 7:22-6. Further, those local government units which receive financial assistance in the form of a federal grant, State Matching Funds pursuant to N.J.A.C. 7:22-2, a Wastewater Treatment Fund or New Jersey Wastewater Treatment Trust loan pursuant to N.J.A.C. 7:22-3 and 4, or a Pinelands Infrastructure Trust grant or loan pursuant to N.J.A.C. 7:22-6 shall be ineligible to receive grant moneys for the same scope of work (planning or design) for the project pursuant to this subchapter.

7:22A-6.6 Project bypassing

(a) (No change.)

(b) Written notice of a bypass action shall be forwarded to the local government unit. As a result of such action, the project on the Project Priority List shall become ineligible to receive Combined Sewer Overflow Account moneys in the applicable funding cycle. This action may allow the next highest ranked project to fall within the fundable range on the Project Priority List. A bypassed project shall remain on the Project Priority List for consideration of financial assistance in future funding cycles.

7:22A-6.7 Pre-application procedures

(a) (No change.)

(b) The Department requires a pre-application conference with potential applicants prior to submission of a formal application for Combined Sewer Overflow Account moneys. During the conference, the Department shall identify and explain all application documents. This conference is not part of the application procedures and verbal statements made during the application procedures and verbal statements made during the conference shall not bind the Department.

7:22A-6.8 Application procedures

(a) For the initial funding cycle, completed applications by local government units requesting Combined Sewer Overflow Account moneys must be received by April 6, 1990 or as otherwise extended by the Department. Since the project's rank on the Project Priority List is the first step in determining eligibility for Combined Sewer Overflow Account moneys, sponsors of projects which are not on the current Project Priority List shall provide the information listed in N.J.A.C. 7:22A-6.4(b) before or concurrently with the complete application and in conformance with applicable deadlines.

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

(d) Any local government unit, which sponsors a project in a jurisdiction in which it is not the governmental entity responsible for the wastewater conveyance and treatment facilities pursuant to the Water Quality Management Plans, to which the combined sewer system contributes shall obtain a resolution from such governmental agency consenting to the undertaking of the local government unit's project prior to or concurrently with the application for Combined Sewer Overflow Account moneys.

(e) Each application for Combined Sewer Overflow Account moneys shall be submitted to the Department in conformance with the time period specified or as otherwise extended by the Department and shall include full and complete documentation and any supplementary materials that the Department requires an applicant to furnish.

(f) (No change.)

(g) The following shall be submitted when applying for a Combined Sewer Overflow Account grant for the planning of dry weather overflow elimination and solids/floatables reduction:

1. An application for a Combined Sewer Overflow Account grant for planning activities. Each application constitutes an agreement to accept the requirements of this subchapter;

2. A resolution passed by the local government unit authorizing the filing of an application for Combined Sewer Overflow Account moneys and specifying the individual authorized to sign the application on behalf of the local government unit. If two or more local government units are involved in the project, a resolution is required from each, indicating the lead applicant and the authorized representative;

3.-5. (No change.)

6. Draft engineering agreements and related cost documentation associated with specific planning activities. Project sponsors must receive authorization to award any subagreement from the Department prior to the award of any subagreement for which cost reimbursement is sought. Note that the local government unit shall be required to execute the approved engineering subagreements prior to or concurrently with the award of a Combined Sewer Overflow Account grant for planning activities;

7.-10. (No change.)

(h) In addition to evidence of planning documentation approval (including evidence of compliance with appropriate Water Quality Management Plans and the Environmental Assessment Requirements for State Assisted Wastewater Treatment Facilities (N.J.A.C. 7:22-10)), the following shall be submitted when applying for a Combined Sewer Overflow Account grant for the design of dry weather overflow elimination and solids/floatables reduction:

1. An application for a Combined Sewer Overflow Account grant for design activities. Each application constitutes an offer to accept the requirements of this subchapter;

2. A resolution passed by the local government unit authorizing the filing of an application for Combined Sewer Overflow Account moneys and specifying the individual authorized to sign the application on behalf of the local government unit. If two or more local government units are involved in the project, a resolution is required from each, indicating the lead applicant and the authorized representative;

3.-5. (No change.)

6. Draft engineering agreements and related cost documentation associated with specific design activities. Project sponsors must receive authorization to award any subagreement from the Department prior to the award of any subagreement for which cost reimbursement is sought. Note that the local government unit shall be required to execute the approved engineering subagreements prior to or concurrently with the award of a Combined Sewer Overflow Account grant for design activities;

7.-10. (No change.)

(i) (No change.)

7:22A-6.9 Evaluation of application

(a) (No change.)

(b) Upon the completion of a full review and evaluation of each application, the Department shall either certify the project for funding or bypass the project for funding in the funding cycle for which the application was submitted.

(c) The Department shall promptly notify an applicant by certified mail if its project has been bypassed. As a result of a project bypass action, the next highest ranked project on the Project Priority List may fall within the fundable range.

7:22A-6.11 Combined Sewer Overflow Account disbursements

(a) For dry weather overflow elimination and solids/floatables reduction planning or design grants, disbursements shall be limited as follows:

1.-4. (No change.)

5. Disbursement for allowable design costs shall not exceed 75 percent of the allowable design cost prior to receiving approval of the contract documents for the building of the project from the Department.

7:22A-6.12 Project initiation

(a) The recipient shall expeditiously initiate and complete the project in accordance with the project schedule contained in the grant agreement. Failure to promptly initiate and complete a project may result in the imposition of sanctions included in this chapter.

(b) The recipient shall not award any subagreement for planning or design of the project until authorization to award has been given by the Department.

7:22A-6.14 Force account work

(a) A recipient shall not use force account work for activities related to the scope of work for which the grant was awarded where costs will exceed $25,000 unless the recipient has received the Department's prior written approval therefor.

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(b) (No change.)

7:22A-6.15 Value engineering

(a) Recipients of Combined Sewer Overflow Account design grants shall conduct value engineering for the project if the total estimated building cost exceeds $10 million.

(b) (No change.)

SUBCHAPTER 7. INTERCONNECTION/CROSS-CONNECTION ABATEMENT ACCOUNT PROCEDURES AND REQUIREMENTS

7:22A-7.1 Applicability

This subchapter constitutes the rules of the Department governing the award of grants pursuant to the Act to any municipality with a stormwater sewer system discharging directly into the salt waters of Monmouth, Ocean, Atlantic and Cape May counties (that is, an affected municipality as defined in N.J.A.C. 7:22A-1.4) for the planning or design of interconnection/cross-connection abatement facilities. These rules prescribe the procedures for the award of grants from the Interconnection/Cross-Connection Abatement Account.

7:22A-7.2 Interconnection/Cross-Connection Abatement Account

(a) The moneys in the Interconnection/Cross-Connection Abatement Account are available for the planning or design of interconnection/cross-connection abatement facilities pursuant to the provisions of this subchapter.

(b) Any affected municipality with an interconnection or cross-connection of stormwater sewer systems and sanitary sewer systems is eligible to receive grant moneys from the Interconnection/Cross-Connection Abatement Account. Applications from those affected municipalities whose submittal under N.J.A.C. 7:22A-4.3 does not identify any interconnection or cross-connection within the municipality shall not be deemed complete by the Department and shall not be processed further.

(c) The consideration for a grant award from the Interconnection/Cross-Connection Abatement Account shall not be used as a defense by the applicant to any action by any agency for the affected municipality's failure to comply with the Act or to obtain and comply with all requisite permits, licenses and operating certificates.

7:22A-7.3 Terms of financial assistance from the Interconnection/Cross-Connection Abatement account

(a) The Department may offer grants from the Interconnection/Cross-Connection Abatement Account for up to 90 percent of the allowable costs for the planning or design of interconnection/cross-connection abatement facilities.

(b) Moneys will be disbursed to recipients, upon request, as work progresses and expenses are incurred and approved by the Department unless otherwise restricted by N.J.A.C. 7:22A-7.11 or unless otherwise indicated in the grant agreement. Affected municipalities shall submit vouchers and other documentation as may be required by the Department in support of their request for disbursement of funds.

(c) The specific terms and conditions of the financial assistance shall be incorporated into the grant agreement to be executed by the recipient and the State.

7:22A-7.4 Initial planning grants

(a) Any affected municipality which has identified an interconnection/cross-connection under N.J.A.C. 7:22A-4 is eligible for an initial planning grant from the Interconnection/Cross-Connection Abatement Account. Initial planning grant award offers may be made by the Department upon the certification of an affected municipality's initial planning grant application.

(b) Initial planning grant applications may be submitted to the Department as of June 15, 1993, but not later than December 15, 1993, unless an extension is granted by the Department. Any affected municipality which requires an extension of the December 15, 1993 initial planning grant application deadline must submit their request for such an extension to the Department by December 15, 1993. The request must state the reasons why an extension should be approved and must identify a proposed date for the submittal of a complete initial planning grant application. Based on this information, the Department will determine whether to approve the extension and establish a revised initial planning grant application deadline.

(c) Initial planning grant award amounts will be as follows:

| Number of stormwater outfalls in affected municipality | Initial grant amount |
|---|---|
| 0- 50 | $15,000 |
| 51-100 | $30,000 |
| Greater than 100 | $50,000 |

In no case will the initial planning grant amount exceed 90 percent of the allowable planning costs.

7:22A-7.5 Project priority for second-round grants

(a) Any affected municipality which has identified an interconnection/cross-connection abatement under N.J.A.C. 7:22A-4 is also eligible for a second-round grant from the Interconnection/Cross-Connection Abatement Account. Second-round grant amounts will be based on the allowable planning or design costs, not to exceed 90 percent of the project costs.

(b) The Department may establish one or more application deadlines for second-round grants. For the first funding cycle, second-round planning grant applications must be submitted to the Department by December 15, 1993 unless an extension is granted by the Department. Second-round planning grant offers will not be made by the Department until all second-round planning grant applications or extension requests have been received and prioritized in accordance with (d) below. Any affected municipality which requires an extension of the December 15, 1993 second-round planning grant application deadline must submit a request for such an extension to the Department by December 15, 1993. The request must state the reasons why an extension should be approved, must identify a target date for the submittal of a complete second-round planning grant application, must include an estimated second-round planning grant amount and include sufficient information to prioritize the project in accordance with (d) below. In instances where a highly ranked project is granted an extension by the Department, the Department may reserve the estimated second-round planning grant amount identified in the affected municipality's extension request and award second-round planning grants to lower ranked projects to the extent sufficient funds are available.

(c) For future funding cycles, affected municipalities shall be notified of applicable second-round planning or design grant application deadlines through the Department's proposed Priority System, Intended Use Plan, and Project Priority List or through mailed notice by the Department.

(d) Second-round planning or design grant applications shall receive priority for financial assistance awards pursuant to this subchapter based on the following point system:

1. Applications which include one or more stormwater outfall discharges to an ocean beach or ocean beaches in municipalities that had ocean beach closures resulting from elevated bacteria levels (based on data from the Cooperative Coastal Monitoring Program administered by the Department) will be given five points for each day in which one or more ocean beaches within the municipality was closed from January 1, 1988, on. Where the Department has determined that an ocean beach closure occurred for causes other than a stormwater outfall discharge no points will be given for that ocean beach closure occurrence.

2. Applications which include one or more stormwater outfall discharges to an estuarine beach or estuarine beaches in municipalities that had estuarine beach closures resulting from elevated bacteria levels (based on data from the Cooperative Coastal Monitoring Program administered by the Department) will be given one point per year for each estuarine beach within the municipality which was closed from January 1, 1988, on. Where the Department has determined that an estuarine beach closure occurred for causes other than a stormwater outfall discharge, no points will be given for that estuarine beach closure occurrence.

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3. Applications which include one or more stormwater outfall discharges to the following areas will receive points as follows:

| Location of Discharge | Points |
|---|---|
| Ocean Beach(es) | 0.9 |
| Estuarine Beach(es) | 0.7 |
| Restricted Shellfish Growing Waters | 0.5 |
| Seasonal Shellfish Growing Waters | 0.3 |
| Approved Shellfish Growing Waters | 0.1 |

4. Applications which include other stormwater outfall discharges and applications with discharges of equal priority will be prioritized based on the average bacteria level of the discharge(s) at the stormwater outfall(s). Applications which address outfalls with higher average bacteria levels will receive priority over those applications with lower average bacteria levels.

(e) Second-round planning or design applications which address stormwater outfall discharges in more than one of the above categories will be assigned the sum total of the points which they are due based on the categories of discharge included in the application.

7:22A-7.6 State and Federal funding

Affected municipalities which receive second-round grants from the Interconnection/Cross-Connection Abatement Account shall be ineligible to receive financial assistance for the same scope of work (planning or design) for the project in the form of a Federal grant, State Matching Funds pursuant to N.J.A.C. 7:22-2, a New Jersey Wastewater Treatment Fund or New Jersey Wastewater Treatment Trust loan pursuant to N.J.A.C. 7:22-3 and 4, or a Pinelands Infrastructure Trust grant or loan pursuant to N.J.A.C. 7:22-6. Further, those affected municipalities which receive financial assistance in the form of a Federal grant, State Matching Funds pursuant to N.J.A.C. 7:22-2, a New Jersey Wastewater Treatment Fund or New Jersey Wastewater Treatment Trust loan pursuant to N.J.A.C. 7:22-3 and 4, or a Pinelands Infrastructure Trust grant or loan pursuant to N.J.A.C. 7:22-6 shall be ineligible to receive second-round grant moneys for the same scope of work (planning or design) for the project pursuant to this subchapter. Notwithstanding the provisions of N.J.A.C. 7:22-3, 4 and 5, projects which do not receive a second-round grant pursuant to this subchapter will be eligible to receive a planning and design allowance pursuant to N.J.A.C. 7:22-5 or 7:22-7, less the amount of their initial planning grant.

7:22A-7.7 Pre-application procedures

(a) Affected municipalities are urged to be familiar with the requirements of this subchapter and to contact the Departmentt prior to the initiation of the planning process so that their projects are in a position to proceed in a timely manner.

(b) The Department requires a pre-application conference with potential applicants prior to submission of a formal application for Interconnection/Cross-Connection Abatement Account moneys. During the conference, the Department shall identify and explain all application documents. This conference is not part of the application procedures and verbal statements made during the conference shall not bind the Department.

7:22A-7.8 Application procedures

(a) Initial planning grant applications and second-round planning grant applications must be submitted in conformance with the schedule in N.J.A.C. 7:22A-7.4(b) and 7.5(b), respectively. Affected municipalities shall be notified of future second-round planning or design grant application deadlines through the Department's proposed Priority System, Intended Use Plan, and Project Priority List or through mailed notice by the Department. All applications must include full and complete documentation and any supplementary materials that the Department requires an applicant to furnish.

(b) Second-round planning or design grant applications will be prioritized by the Department in accordance with the criteria set forth at N.J.A.C. 7:22A-7.5. The award of second-round grants from the Interconnection/Cross-Connection Abatement Account will be based on the application's priority relative to other applications and the amount of available funds.

(c) Submissions which do not substantially comply with this subchapter or which are deemed incomplete shall not be processed further. Such applicants will be notified in a timely fashion as to the extent of deficiencies in their submissions.

(d) Processing of an Interconnection/Cross-Connection Abatement Account application generally requires 60 calendar days after receipt of a complete application by the Department.

(e) The following shall be submitted when applying for an initial or second-round grant from the Interconnection/Cross-Connection Abatement Account for the planning of interconnection/cross-connection abatement facilities.

1. An application for an Interconnection/Cross-Connection Abatement Account grant for planning activities. Each application constitutes an agreement to accept the requirements of this subchapter;

2. A resolution passed by the affected municipality authorizing the filing of an application for Interconnection/Cross-Connection Abatement Account moneys and specifying the individual authorized to sign the application on behalf of the affected municipality. If two or more affected municipalities are involved in the project, a resolution is required from each, indicating the lead applicant and the authorized representative;

3. Assurance of compliance with the requirements of Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and the New Jersey Law Against Discrimination (N.J.A.C. 10:5-1 et seq.) (CGA Form LP-5);

4. The final map and the additional information developed under N.J.A.C. 7:22A-4.3 which identifies specific interconnections or cross-connections. In the case of an initial planning grant application, the final map and the additional information may be limited to the area or section of the municipality in which an interconnection/cross-connection abatement need has been identified;

5. A plan of study presenting:

i. The proposed planning area;

ii. An identification of the entity or entities that will be conducting the planning;

iii. The nature and scope of the planning of the proposed project as well as a schedule for the completion of identified tasks, including those tasks necessary to adequately assess the environmental impacts of the alternatives and the selected plan and the schedule for a proposed public participation program as set forth at the Environmental Assessment Requirements for State Assisted Wastewater Treatment Facilities (N.J.A.C. 7:22-10); and

iv. A description of the anticipated construction required for abatement and an estimate of construction costs (including an estimate of anticipated designs costs);

6. Comments or approvals of relevant State, local and Federal agencies;

7. Draft engineering agreement(s) and related cost documentation associated with specific planning activities. Note that the affected municipality shall be required to execute the approved engineering subagreements prior to or concurrently with the award of an Interconnection/Cross-Connection Abatement Account grant for planning activities;

8. Adequate information to ensure compliance with the regulations entitled Awarding Contracts for State Assisted Projects to Small Business Concerns Owned and Controlled by Socially and Economically Disadvantaged Individuals (N.J.A.C. 7:22-9);

9. Proposed intermunicipal or other agreements necessary for the construction and operation of the proposed facilities, if applicable;

10. A schedule for initiation and completion of the planning, design, and building of the project, including milestones; and

11. Certification from the affected municipality that at least 10 percent of the planning costs for the project must be provided by the affected municipality.

(f) In order to qualify for a design grant, evidence of planning documentation approval (including evidence of compliance with appropriate Water Quality Management Plans and the Environmental Assessment Requirements for State Assisted Wastewater Treatment Facilities (N.J.A.C. 7:22-10)) must be provided. All project design work must be in conformance with the approved project planning work. Any variations shall be specifically addressed by the recipient

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and approved by the Department before the project design will be considered complete. The following information must be submitted when applying for an Interconnection/Cross-Connection Abatement Account grant for the design of interconnection/cross-connection abatement facilities:

1. An application for an Interconnection/Cross-Connection Abatement Account grant for design activities. Each application constitutes an agreement to accept the requirements of this subchapter;

2. A resolution passed by the affected municipality authorizing the filing of an application for Interconnection/Cross-Connection Abatement Account moneys and specifying the individual authorized to sign the application on behalf of the affected municipality. If two or more affected municipalities are involved in the project, a resolution is required from each, indicating the lead applicant and the authorized representative;

3. Assurance of compliance with the requirements of Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and the New Jersey Law Against Discrimination (N.J.A.C. 10:5-1 et seq.) (CGA Form LP-5);

4. A plan of study presenting:

i. The proposed project area;

ii. An identification of the entity or entities that will design the project;

iii. The nature and scope of the design of the proposed project as well as a schedule for the completion of identified tasks; and

iv. A description of the estimated building costs for the project;

5. Comments or approvals of relevant State, local and federal agencies;

6. Draft engineering agreement(s) and related cost documentation associated with specific design activities. Note that the affected municipality shall be required to execute the approved engineering subagreements prior to or concurrently with the award of an Interconnection/Cross-Connection Abatement Account grant for design activities;

7. Adequate information to ensure compliance with the regulations entitled Awarding Contracts for State Assisted Projects to Small Business Concerns Owned and Controlled by Socially and Economically Disadvantaged Individuals (N.J.A.C. 7:22-9);

8. Proposed intermunicipal or other agreements necessary for the construction and operation of the proposed facilities, if applicable;

9. A schedule for initiation and completion of the construction of the project including milestones; and

10. Certification from the affected municipality that at least 10 percent of the design costs for the project must be provided by the affected municipality.

(g) All mapping related submittals must be made in a format compatible with the Department's geographical information system (GIS).

7:22A-7.9 Evaluation of application

(a) Each application shall be subject to:

1. Preliminary administrative review to determine the completeness of the application. The applicant will be notified of the completeness or deficiency of the application;

2. Technical and scientific evaluation to determine the merit and relevance of the project to the Department's objectives and the objectives of the Act;

3. Budget evaluation to determine whether proposed project costs are reasonable, applicable, and allowable; and

4. Final administrative evaluation.

(b) Upon the completion of a full review and evaluation of each application, the Department will either certify the project for funding or bypass the project application and notify the applicant of such action. As a result of a project bypass action, the next highest ranked project may fall within the fundable range.

7:22A-7.10 Supplemental information

At any stage during the evaluation process, the Department may require supplemental documents or information necessary to complete its full review of the application. The Department may suspend its evaluation until such additional information or documents have been received.

7:22A-7.11 Interconnection/Cross-Connection Abatement Account disbursements

(a) For initial planning grants and second-round planning or design grants, disbursements shall be limited as follows:

1. Disbursements for allowable planning costs shall not exceed 50 percent of the grant amount prior to the submission of complete planning documentation;

2. Disbursements for allowable planning costs shall not exceed 75 percent of the grant amount prior to the issuance of an environmental assessment in accordance with N.J.A.C. 7:22-10;

3. Disbursements for allowable design costs shall not be made until all planning requirements have been completed to the Department's satisfaction;

4. Disbursements for allowable design costs shall not exceed 50 percent of the allowable design costs prior to the submittal of plans, specifications, contract documents and an engineer's technical design report for the project; and

5. Disbursement for allowable design costs shall not exceed 75 percent of the allowable design costs prior to receiving approval of the contract documents for the building of the project from the Department.

7:22A-7.12 Project initiation

(a) The recipient shall expeditiously initiate and complete the project in accordance with the project schedule contained in the grant agreement. Failure to promptly initiate and complete a project may result in the imposition of sanctions included in this chapter.

(b) The recipient shall not award any subagreement(s) for planning or design of the project until authorization to award has been given by the Department.

7:22A-7.13 Allowable project costs

(a) Project costs shall be determined to be allowable to the extent permitted by this chapter and the grant agreement. Allowable project costs may include:

1. The costs of subagreements for planning or design of the project; and

2. The costs for establishing or using small, minority, and women's business liaison services.

(b) Notwithstanding (a) above, unallowable project costs shall include, but not be limited to:

1. The costs of subagreements for which authorization to award from the Department was not received in advance of the award of the subagreement for planning or design services;

2. The costs for work that the Department determines is not in compliance with the approved scope of work for the project identified in the grant agreement; and

3. The costs for work not in compliance with the applicable provisions of N.J.A.C. 7:22A-1, 2 and this subchapter or approved subagreements.

7:22A-7.14 Force account work

(a) A recipient shall not use force account work for activities related to the scope of work for which the grant was awarded where costs will exceed $25,000 unless the recipient has received the Department's prior written approval therefor.

(b) The recipient shall demonstrate to the Department's satisfaction that:

1. The work can be accomplished cost effectively by the use of force account; or

2. Emergency circumstances necessitate its use.

7:22A-7.15 Value engineering

(a) The recipient shall conduct value engineering for the project if the total estimated building cost exceeds $10 million.

(b) The value engineering recommendations shall be implemented to the maximum extent feasible.

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# HEALTH

## (a)

### BIRTH CERTIFICATES

### Creation of Birth Record

### Adopted Repeal and New Rules: N.J.A.C. 8:2

Proposed: December 7, 1992 at 24 N.J.R. 4325(a); see also 25 N.J.R. 660(a).

Adopted: July 14, 1993 by Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health.

Filed: July 16, 1993 as R.1993 d.397, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:8-23.

Effective Date: August 16, 1993.

Expiration Date: August 16, 1998.

**Summary** of Public Comments and Agency Responses:

Comments were received from the following organizations and individuals:

Melanie Griffin, Commission on Sex Discrimination; Lisa Glick-Zucker, ACLU; Carole Stapleton-Rhodes, UMD, Newark; Mary McTighue, Elizabeth General Hospital; Florence Ewasko, Registrar, Borough of Ringwood; Margherita Kaplan, Registrar, New Brunswick; Robert Uhrik; Elizabeth Cooper, representing Gibbons Fellowship in Publication Interest.

1. COMMENT: A concern was raised that the proposed new rules will have a social impact by causing breakdown in morality and that individuals could not trace their roots.

RESPONSE: The birth record rules are merely a procedure for the uniform recording of birth names chosen by children's parents. The rules do not dictate any naming policy: they simply permit parents to choose their children's names without being forced to go to court to do so.

2. COMMENT: Registrars would have to be mediators for parents who would argue about the choice of names.

RESPONSE: The chapter provides for situations where parents cannot agree on the choice of a surname. Once the birth record has been accepted for filing, the name chosen cannot be changed except through a legal name change proceeding.

3. COMMENT: Requiring both parents to sign each birth certificate will burden the institution in terms of time and money.

RESPONSE: Signature of both parents is only required when there is a dispute as to the parents to be named on the certificate or when the parents are not married to each other. The requirement for one or both parents to sign acknowledging the child's name will save time and money by reducing the claims of errors caused by misspelling of names. Most states require the parents to sign birth certificates.

4. COMMENT: Will there be restrictions on what the registrar will accept as the stated reason for parents' absence?

RESPONSE: The rule has been changed in response to the comment. No reason is required; merely a notation that the other parent is not available.

5. COMMENT: Please define joint custody.

RESPONSE: The sense of that phrase, as used in the proposed rules, was meant in the colloquial sense, that is, when both parents have custody, and not meant to invoke the legal term of art and all of its ramifications. The wording has been changed to reflect this.

6. COMMENT: Are there any exceptions of the five day rule in the case of the Orthodox Jewish population?

RESPONSE: Every effort should be made to have the record filed within five days. The State Registrar should be contacted where special circumstances prevail.

7. COMMENT: Please explain how someone other than the woman giving birth would be listed as the baby's mother.

RESPONSE: For example, the courts and legislature are responsible for determining motherhood in cases of surrogacy.

8. COMMENT: More than the proposed five days from birth should be considered to allow the parents to choose a name.

RESPONSE: The five day filing period is mandated by N.J.S.A. 26:8-28. The State Registrar should be contacted where special circumstances prevail.

9. COMMENT: Failure to recognize gay and lesbian parents may violate laws against discrimination. Therefore the wording in the policy describing parents should be gender neutral.

RESPONSE: The wording of the rule has been revised to comply with said recommendation.

10. COMMENT: The name of both parents should be required on the birth record and the names of both parents should be provided by the custodial parent or parents.

RESPONSE: While the Department recognizes that it is preferable to have both names recorded on the birth record, it is also important that the record be as accurate as possible. If the mother is not married at the time of birth, the name of the father may not be evident and/or may not be accurately provided. In this case, it is appropriate to require that the named parent acknowledge the child in writing before it is entered on the record. This will assure greater accuracy of the birth records created. In all cases, the name of a parent can be changed by an appropriate court order.

11. COMMENT: A commenter asked the Department to clarify which name, or both names, would be considered the surname, in the case of a hyphenated name.

RESPONSE: The Department has amended the definition to clarify that, in the case of a hyphenated last name, both names, including the hyphen, are considered the surname.

12. COMMENT: The A.C.L.U. commented that the text of N.J.A.C. 8:2-1.4(a) and (b) is not consistent with the Parentage Act, N.J.S.A. 9:17-38.

RESPONSE: The Department has changed the text on adoption to conform to the Act, including the 300 day period of time specified in section 6 of the Act.

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

CHAPTER 2
BIRTH CERTIFICATES

SUBCHAPTER 1. CREATION OF BIRTH RECORD

8:2-1.1 Purpose and scope

These rules create the birth record and permit the parents, at the time of birth, to choose any name for their child without restrictions, except for names which contain obscenities or numerical characters. The rules set forth the options open to a parent in the naming of the child, and clarify who the informant of the birth information should be.

8:2-1.2 Definitions

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

"Commissioner" means the State Commissioner of Health.

"Department" means the New Jersey State Department of Health.

"Informant" means the name of the individual providing the personal particulars for the preparation of the birth certificate.

"State Registrar" means the New Jersey State Registrar of Vital Statistics.

"Surname" means the last complete name on a birth certificate *[without a hyphen, or the last full name preceeding the hyphen]* ***without a hyphen or both names including the hyphen if the last names on the birth certificate are hyphenated***.

8:2-1.3 Designation of child's name

(a) The designation of a child's name including the surname is the right of the child's parent(s). The child may be given any chosen name(s) or surname, except that the State Registrar may reject a name that contains an obscenity, numerals, or combination of letters and numerals or a name that is illegible. The chosen name shall be printed on the back of the birth record and the birth record shall be signed by one or both parents. The hospital official who witnesses the signing shall also sign the birth record.

1. *[In cases where the parents are not married, or divorced or where either parent is unavailable for any reason, the choice of the child's name(s) rests with the parent who has custody of the newborn child. That parent shall state the reason for the absence of the other

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parent in the space for the parents' signature and thereafter shall be the sole informant for the purpose of compliance with N.J.S.A. 26:8-36 and this subchapter.]* ***Where either parent is unavailable for any reason, the choice of the child's name(s) rests with the parent who has custody of the newborn child. That parent shall state in writing on the back of the birth record that the other parent is not available; thereafter the recording parent shall be the sole informant for the purpose of compliance with N.J.S.A. 26:8-26 and this subchapter.***

2. In cases where *[the]* ***both*** parents have *[joint]* custody *[and the father is not available, the choice of the child's name rests with the child's mother who shall state in writing on the back of the birth record that the father is not available. In cases where the parents have joint custody of the child, are both available, and disagree on the selection of a surname, the surname selected by the father and the surname selected by the mother shall both be entered on the certificate, separated by a hyphen, with the selected names entered in alphabetic order.]* ***of the child, are both available, and disagree on the selection of a surname, the surname selected by one parent and the surname selected by the other parent shall both be entered on the certificate, separated by a hyphen, with the selected names entered in alphabetic order.***

(b) The parents or custodian of the child shall have five days from the child's birth to decide the child's surname. If no designation is made within that time, and no surname has been registered pursuant to (a)2 above, or if the chosen surname is rejected by the State Registrar, for the reasons specified in (a) above, the child's surname shall be recorded as *[the mother's surname and the father's surname in alphabetic order, separated by a hyphen. If the mother and father]* ***both parents surnames in alphabetical order separated by a hyphen.*** If the *[mother and father]* ***parents*** disagree on the selection of a given name, or if the State Registrar rejects the given name chosen by the parents or parent, for the reasons specified in (a) above, a dash (–) shall be entered in the space allotted for a given name on the certificate. After five days, any surname assigned by the registrar, a surname registered pursuant to (a)2 above, or the dash designation may only be changed through the procedures set out in N.J.S.A. 26:8-48 and 2A:52-4.

8:2-1.4 Names of parents

*[(a) The name of the father should be entered on the birth record. If the mother is married at the time of birth, the mother's husband is presumed to be the child's natural father and his name shall be listed as the child's father. If the mother is not married at the time of the birth, the name of the father shall only be listed on the birth record if the named father agrees and signs the back of the birth record. The recorded name of the father may be changed by an appropriate court order establishing paternity or by a denial of paternity on the back of the birth record by the named father and agreed by the mother.

(b) The name of the child's mother shall be recorded as that of the woman giving birth, unless another woman is found by a court of competent jurisdiction to be the child's mother.]*

***(a) The woman giving birth shall be recorded as a parent.***

***(b) If the birthing parent is married at the time of the birth, or was married and the child was born within 300 days after the marriage was terminated by death, annulment or divorce, the spouse's name shall be listed on the birth record unless the spouse denies parentage and both the husband and wife agree and acknowledge the denial in writing on the back of the birth record.***

***(c) If the birthing parent is not married and was not married within 300 days of the birth, the name of the parent not giving birth should be provided. The name provided by the informant will only be entered on the birth record if both parents acknowledge the child by signing the back of the birth record.***

***(d) The name recorded for either parent may be changed by order of a court of competent jurisdiction.****

8:2-1.5 Informant

The custodial parent(s) of a child shall act as informant and provide the necessary information to complete the original birth certificate. The informant shall certify on forms provided by the State Registrar that the information provided is accurate and true to the best of the informant's knowledge.

SUBCHAPTER 2. FEES

8:2-2.1 Fees; Refund of fees; excess payment

(a) Fees for birth record searches, copies of birth records or changes to birth records are specified in N.J.S.A. 26:8-40.1; 26:8-62; 26:8-63; 26:8-64; and 2A:52-4 (Vital Statistics).

(b) In the instance of individuals forwarding funds in excess of those fees specified in N.J.S.A. 26:8-40.1, 26:8-61, 26:8-62, 26:8-64 and 2A:52-4 (Vital Statistics), the New Jersey State Department of Health will not make refunds of $1.00 or less.

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## (a)

## OFFICE OF HEALTH POLICY AND RESEARCH

### Notice of Rule Invalidation
### State Health Plan Rules
### N.J.A.C. 8:100

**Take notice** that the decision of the Superior Court of New Jersey, Appellate Division, in *In the Matter of the Adoption of Regulations Governing the State Health Plan, N.J.A.C. 8:100, et seq.*, 262 *N.J. Super.* 469 (App. Div. 1993), affected the validity of the State Health Plan Rules at N.J.A.C. 8:100.

Please contact the Department of Health regarding any further action on this case.

This notice is provided by the Office of Administrative Law pursuant to N.J.A.C. 1:30-1.13.

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# HUMAN SERVICES

## (b)

## DIVISION OF FAMILY DEVELOPMENT

### Child Care Services Manual
### Public Assistance Manual
### Assistance Standards Handbook
### Family Development Program Manual
### Child Care: Entrance/Exit Levels for New Jersey Cares for Kids (NJCK) Certificate Program; Child Care Payment Rates/Age Categories; Co-payment for Child Care

### Adopted Amendments: N.J.A.C. 10:15-1.2; 10:15A-1.2; 10:15B-1.2 and 2.1; 10:15C-1.1; 10:81-14.18A; 10:82-5.3; and 10:86-10.2 and 10.6

Proposed: April 19, 1993 at 25 N.J.R. 1692(a).

Adopted: July 12, 1993 by William Waldman, Commissioner, Department of Human Services.

Filed: July 15, 1993 as R.1993 d.396, **without change**.

Authority: N.J.S.A. 30:1-12 and 44:10-3; Family Support Act, Public Law 101-485; Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, Sections 5081 and 5082; and Family Development Act, P.L. 1991, c.523.

Effective Date: August 16, 1993.

Expiration Date: N.J.A.C. 10:15, 10:15A, 10:15B and 10:15C, January 1, 1995;
N.J.A.C. 10:81 and 10:82, August 24, 1994;
N.J.A.C. 10:86, September 21, 1997.

**Summary** of Public Comments and Agency Responses:
**No comments received.**

**Full text** of the adoption follows:

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10:15-1.2 Definitions

The following words and terms, when used in this chapter and N.J.A.C. 10:15A, 15B and 15C, shall have the following meanings, unless the context clearly indicates otherwise.

. . .

"At-Risk" means working low-income families whose income upon entry into the program is at or below 200 percent of the Federal Poverty Income Guidelines, which are published annually in the Federal Register. Such families must be in need of child care assistance in order to remain employed (or to accept employment) and to avoid dependency on public assistance (that is, AFDC).

. . .

"Low income" for IV-A At-Risk means families with gross annual incomes at or below 200 percent of the Federal Poverty Income Guidelines, as determined by family size, which are published annually in the Federal Register.

. . .

10:15A-1.2 Payment policies

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

(c) The maximum child care payment rates are set forth in Tables I, II and III below. The maximum child care payment rates utilized in the Department of Human Services child care service programs are available through a written request to the New Jersey Department of Human Services, Division of Family Development, CN 716, Trenton, NJ 08625, or the local Division of Youth and Family Services Regional Office, the county welfare agency or the county designated agency.

1.-3. (No change.)

4. Tables I, II, and III specify monthly, weekly and daily rates for the various age categories of children based on the hours of care provided.

NJCK CHILD CARE CERTIFICATE/VOUCHER MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

| Child's Service Category | Hours of Care Provided: Full Time 6 hrs. or more/day | Hours of Care Provided: Part-Time Less than 6 hrs./day |
|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | |
| Monthly | $503.15 | $251.58 |
| Weekly | $116.20 | $ 58.10 |
| Daily Equivalent | $ 23.24 | $ 11.62 |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | |
| Monthly | $503.15 | $251.58 |
| Weekly | $116.20 | $ 58.10 |
| Daily Equivalent | $ 23.24 | $ 11.62 |
| Pre-Schoolers (2.5 up to 5 yrs.) | | |
| Monthly | $414.82 | $207.41 |
| Weekly | $ 95.80 | $ 47.90 |
| Daily Equivalent | $ 19.16 | $ 9.58 |
| Kindergartner & School-Agers (5-13 yrs.) | | |
| Monthly | $414.82 | $207.41 |
| Weekly | $ 95.80 | $ 47.90 |
| Daily Equivalent | $ 19.16 | $ 9.58 |
| Special Needs | | |
| Infants/Toddlers (0 up to 2 yrs.) | | |
| Monthly | $503.15 | $251.58 |
| Weekly | $116.20 | $ 58.10 |
| Daily Equivalent | $ 23.24 | $ 11.62 |
| Special Needs | | |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | |
| Monthly | $503.15 | $251.58 |
| Weekly | $116.20 | $ 58.10 |
| Daily Equivalent | $ 23.24 | $ 11.62 |
| Special Needs (2.5 up to 19 yrs.) | | |
| Monthly | $414.82 | $207.41 |
| Weekly | $ 95.80 | $ 47.90 |
| Daily Equivalent | $ 19.16 | $ 9.58 |

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.

NJCK CHILD CARE CERTIFICATE/VOUCHER MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

| Child's Service Category | Hours of Care Provided: Full Time 6 hrs. or more/day | Hours of Care Provided: Part-Time Less than 6 hrs./day |
|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | |
| Monthly | $397.50 | $198.75 |
| Weekly | $ 91.80 | $ 45.90 |
| Daily Equivalent | $ 18.36 | $ 9.18 |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | |
| Monthly | $397.50 | $198.75 |
| Weekly | $ 91.80 | $ 45.90 |
| Daily Equivalent | $ 18.36 | $ 9.18 |
| Pre-Schoolers (2.5 up to 5 yrs.) | | |
| Monthly | $309.17 | $154.59 |
| Weekly | $ 71.40 | $ 35.70 |
| Daily Equivalent | $ 14.28 | $ 7.14 |
| Kindergartner & School-Agers (5-13 yrs.) | | |
| Monthly | $309.17 | $154.59 |
| Weekly | $ 71.40 | $ 35.70 |
| Daily Equivalent | $ 14.28 | $ 7.14 |
| Special Needs | | |
| Infants/Toddlers (0 up to 2 yrs.) | | |
| Monthly | $485.83 | $242.92 |
| Weekly | $112.20 | $ 56.10 |
| Daily Equivalent | $ 22.44 | $ 11.22 |
| Special Needs | | |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | |
| Monthly | $485.83 | $242.92 |
| Weekly | $112.20 | $ 56.10 |
| Daily Equivalent | $ 22.44 | $ 11.22 |
| Special Needs (2.5 up to 19 yrs.) | | |
| Monthly | $397.50 | $198.75 |
| Weekly | $ 91.80 | $ 45.90 |
| Daily Equivalent | $ 18.36 | $ 9.18 |

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.

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NJCK CHILD CARE CERTIFICATE/VOUCHER MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

| Child's Service Category | Hours of Care Provided: Full Time 6 hrs. or more/day | Hours of Care Provided: Part-Time Less than 6 hrs./day |
|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | |
| Monthly | $238.58 | $119.29 |
| Weekly | $ 55.10 | $ 27.55 |
| Daily Equivalent | $ 11.02 | $ 5.51 |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | |
| Monthly | $238.58 | $119.29 |
| Weekly | $ 55.10 | $ 27.55 |
| Daily Equivalent | $ 11.02 | $ 5.51 |
| Pre-Schoolers (2.5 up to 5 yrs.) | | |
| Monthly | $185.32 | $ 92.66 |
| Weekly | $ 42.80 | $ 21.40 |
| Daily Equivalent | $ 8.56 | $ 4.28 |
| Kindergartner & School-Agers (5-13 yrs.) | | |
| Monthly | $185.32 | $ 92.66 |
| Weekly | $ 42.80 | $ 21.40 |
| Daily Equivalent | $ 8.56 | $ 4.28 |
| Special Needs Infants/Toddlers (0 up to 2 yrs.) | | |
| Monthly | $291.40 | $145.70 |
| Weekly | $ 67.30 | $ 33.65 |
| Daily Equivalent | $ 13.46 | $ 6.73 |
| Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.) | | |
| Monthly | $291.40 | $145.70 |
| Weekly | $ 67.30 | $ 33.65 |
| Daily Equivalent | $ 13.46 | $ 6.73 |
| Special Needs (2.5 up to 19 yrs.) | | |
| Monthly | $238.58 | $119.29 |
| Weekly | $ 55.10 | $ 27.55 |
| Daily Equivalent | $ 11.02 | $ 5.51 |

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.

(d)-(g) (No change.)

10:15B-1.2 Eligibility for IV-A "At-Risk" Child Care (ARCC) Program

(a) (No change.)

(b) Families shall be working low-income families or a working low-income family that has a protective services child in need of child care services residing in the family's home.

1. "Low-income" families are defined for purposes of this program as families whose gross annual income for the family size is at or below 200 percent of the Federal Poverty Income Guidelines published annually in the Federal Register (reference the Federal Register, Vol. 57, No. 31, dated February 14, 1992, page 5455). Subsequent updates to these Guidelines in the Federal Register will be published as a public notice by the Department in the New Jersey Register.

2. The annual gross income of the family must fall at or below 200 percent of the Federal Poverty Income Guidelines for the family size to establish income eligibility.

i. (No change.)

3. Recipient families may remain eligible under the IV-A At-Risk Program as long as the family's annual gross income, for the family size, does not exceed 75 percent of the State's median income (SMI) for a family of the same size. (The SMI for states is published by the Federal Administration for Children and Families in the Federal Register. The SMI was last published in the Federal Register, Vol. No. 53, No. 64, April 4, 1988. Subsequent updates to the SMI will be published as a public notice by the Department in the New Jersey Register.)

(c)-(h) (No change.)

10:15B-2.1 Description of CCDBG Program

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

(d) Priority consideration and placement of children through CCDBG assistance is given to children who are from families with "very low income," as well as children who have been identified as protective services children or as having special needs (see N.J.A.C. 10:15-1.2 for definition of a special needs child).

1. Families with "very low income" are defined as families with incomes at or below 200 percent of the Federal Poverty Income Guidelines, as determined by family size.

(e) Groups identified for priority CCDBG participation include:

1.-2 (No change.)

3. Children in families with very low income at or below 200 percent of the Federal Poverty Income Guidelines.

4. (No change.)

10:15C-1.1 Co-payment procedures

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

(d) The amount of the required co-payment is based on the family's annual gross income level, family size, number of children, and number of children in care. Assessed co-payments are apportioned weekly and are due for the entire period of time that subsidized child care assistance is received. Holidays, emergency closings, and absences do not exclude or reduce the required co-payment. There are two co-payment scales:

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Table I
CHILD CARE CO-PAYMENT SCALE
FULL TIME CARE†

| Weekly Full Time Co-Payment | | Monthly Full Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income†††† | | | | |
|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 2 | 3 | 4 | 5 | 6 |
| $1.10 | $0.55 | $4.76 | $2.38 | 0% - 5% | 0 - 1,768 | 0 - 2,184 | 0 - 2,600 | 0 - 3,016 | 0 - 3,432 |
| $4.40 | $2.20 | $19.05 | $9.53 | 6% - 10% | 1,769 - 3,536 | 2,185 - 4,368 | 2,601 - 5,200 | 3,017 - 6,031 | 3,433 - 6,863 |
| $6.60 | $3.30 | $28.58 | $14.29 | 11% - 15% | 3,537 - 5,304 | 4,369 - 6,552 | 5,201 - 7,799 | 6,032 - 9,047 | 6,864 - 10,295 |
| $9.90 | $4.95 | $42.87 | $21.43 | 16% - 20% | 5,305 - 7,071 | 6,553 - 8,735 | 7,800 - 10,399 | 9,048 - 12,063 | 10,296 - 13,727 |
| $12.10 | $6.05 | $52.39 | $26.20 | 21% - 25% | 7,072 - 8,839 | 8,736 - 10,919 | 10,400 - 12,999 | 12,064 - 15,079 | 13,728 - 17,159 |
| $15.40 | $7.70 | $66.68 | $33.34 | 26% - 30% | 8,840 - 10,607 | 10,920 - 13,103 | 13,000 - 15,599 | 15,080 - 18,094 | 17,160 - 20,590 |
| $19.80 | $9.90 | $85.73 | $42.87 | 31% - 35% | 10,608 - 12,375 | 13,104 - 15,287 | 15,600 - 18,198 | 18,095 - 21,110 | 20,591 - 24,022 |
| $24.20 | $12.10 | $104.79 | $52.39 | 36% - 40% | 12,376 - 14,143 | 15,288 - 17,471 | 18,199 - 20,798 | 21,111 - 24,126 | 24,023 - 27,454 |
| $29.70 | $14.85 | $128.60 | $64.30 | 41% - 45% | 14,144 - 15,911 | 17,472 - 19,655 | 20,799 - 23,398 | 24,127 - 27,141 | 27,455 - 30,885 |
| $35.20 | $17.60 | $152.42 | $76.21 | 46% - 50% | 15,912 - 17,679 | 19,656 - 21,839 | 23,399 - 25,998 | 27,142 - 30,157 | 30,886 - 34,317 |
| $40.70 | $20.35 | $176.23 | $88.12 | 51% - 55% | 17,680 - 19,446 | 21,840 - 24,022 | 25,999 - 28,597 | 30,158 - 33,173 | 34,318 - 37,749 |
| $47.30 | $23.65 | $204.81 | $102.40 | 56% - 60% | 19,447 - 21,214 | 24,023 - 26,206 | 28,598 - 31,197 | 33,174 - 36,188 | 37,750 - 41,180 |
| $55.00 | $27.50 | $238.15 | $119.08 | 61% - 65% | 21,215 - 22,982 | 26,207 - 28,390 | 31,198 - 33,797 | 36,189 - 39,204 | 41,181 - 44,612 |
| $62.70 | $31.35 | $271.49 | $135.75 | 66% - 70% | 22,983 - 24,750 | 28,391 - 30,574 | 33,798 - 36,397 | 39,205 - 42,220 | 44,613 - 48,044 |
| $67.10 | $33.55 | $290.54 | $145.27 | 71% - 75% | 24,751 - 26,518 | 30,575 - 32,758 | 36,398 - 38,996 | 42,221 - 45,236 | 48,045 - 51,476 |

| Weekly Full Time Co-Payment | | Monthly Full Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 7 | 8 | 9 | 10 | 11 | 12 |
| $1.10 | $0.55 | $4.76 | $2.38 | 0% - 5% | 0 - 3,510 | 0 - 3,588 | 0 - 3,666 | 0 - 3,744 | 0 - 3,822 | 0 - 3,900 |
| $4.40 | $2.20 | $19.05 | $9.53 | 5% - 10% | 3,511 - 7,019 | 3,589 - 7,176 | 3,667 - 7,332 | 3,745 - 7,488 | 3,823 - 7,644 | 3,901 - 7,800 |
| $6.60 | $3.30 | $28.58 | $14.29 | 11% - 15% | 7,020 - 10,529 | 7,177 - 10,763 | 7,333 - 10,997 | 7,489 - 11,231 | 7,645 - 11,465 | 7,801 - 11,699 |
| $9.90 | $4.95 | $42.87 | $21.43 | 16% - 20% | 10,530 - 14,039 | 10,764 - 14,351 | 10,998 - 14,663 | 11,232 - 14,975 | 11,466 - 15,287 | 11,700 - 15,599 |
| $12.10 | $6.05 | $52.39 | $26.20 | 21% - 25% | 14,040 - 17,548 | 14,352 - 17,939 | 14,664 - 18,329 | 14,976 - 18,719 | 15,288 - 19,109 | 15,600 - 19,499 |
| $15.40 | $7.70 | $66.68 | $33.34 | 26% - 30% | 17,549 - 21,058 | 17,940 - 21,527 | 18,330 - 21,995 | 18,720 - 22,463 | 19,110 - 22,931 | 19,500 - 23,399 |
| $19.80 | $9.90 | $85.73 | $42.87 | 31% - 35% | 21,059 - 24,568 | 21,528 - 25,114 | 21,996 - 25,660 | 22,464 - 26,206 | 22,932 - 26,752 | 23,400 - 27,298 |
| $24.20 | $12.10 | $104.79 | $52.39 | 36% - 40% | 24,569 - 28,077 | 25,115 - 28,702 | 25,661 - 29,326 | 26,207 - 29,950 | 26,753 - 30,574 | 27,299 - 31,198 |
| $29.70 | $14.85 | $128.60 | $64.30 | 41% - 45% | 28,078 - 31,587 | 28,703 - 32,290 | 29,327 - 32,992 | 29,951 - 33,694 | 30,575 - 34,396 | 31,199 - 35,098 |
| $35.20 | $17.60 | $152.42 | $76.21 | 46% - 50% | 31,588 - 35,097 | 32,291 - 35,878 | 32,993 - 36,658 | 33,695 - 37,438 | 34,397 - 38,218 | 35,099 - 38,998 |
| $40.70 | $20.35 | $176.23 | $88.12 | 51% - 55% | 35,098 - 38,606 | 35,879 - 39,465 | 36,659 - 40,323 | 37,439 - 41,181 | 38,219 - 42,039 | 38,999 - 42,897 |
| $47.30 | $23.65 | $204.81 | $102.40 | 56% - 60% | 38,607 - 42,116 | 39,466 - 43,053 | 40,324 - 43,989 | 41,182 - 44,925 | 42,040 - 45,861 | 42,898 - 46,797 |
| $55.00 | $27.50 | $238.15 | $119.08 | 61% - 65% | 42,117 - 45,625 | 43,054 - 46,641 | 43,990 - 47,655 | 44,926 - 48,669 | 45,862 - 49,683 | 46,798 - 50,697 |
| $62.70 | $31.35 | $271.49 | $135.75 | 66% - 70% | 45,626 - 49,135 | 46,642 - 50,229 | 47,656 - 51,321 | 48,670 - 52,413 | 49,684 - 53,505 | 50,698 - 54,597 |
| $67.10 | $33.55 | $290.54 | $145.27 | 71% - 75% | 49,136 - 52,645 | 50,230 - 53,816 | 51,322 - 54,986 | 52,414 - 56,156 | 53,506 - 57,326 | 54,598 - 58,496 |

†Full time care is defined as six (6) or more hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $1.00 ($2.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.

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Table II
CHILD CARE CO-PAYMENT SCALE
PART-TIME CARE†

| Weekly Part-Time Co-Payment | | Monthly Part-Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income†††† | | | | |
|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 2 | 3 | 4 | 5 | 6 |
| $0.00 | $0.00 | $0.00 | $0.00 | 0% - 5% | 0 - 1,768 | 0 - 2,184 | 0 - 2,600 | 0 - 3,016 | 0 - 3,432 |
| $2.20 | $1.10 | $9.53 | $4.76 | 6% - 10% | 1,769 - 3,536 | 2,185 - 4,368 | 2,601 - 5,200 | 3,017 - 6,031 | 3,433 - 6,863 |
| $3.30 | $1.65 | $14.29 | $7.14 | 11% - 15% | 3,537 - 5,304 | 4,369 - 6,552 | 5,201 - 7,799 | 6,032 - 9,047 | 6,864 - 10,295 |
| $4.40 | $2.20 | $19.05 | $9.53 | 16% - 20% | 5,305 - 7,071 | 6,553 - 8,735 | 7,800 - 10,399 | 9,048 - 12,063 | 10,296 - 13,727 |
| $5.50 | $2.75 | $23.82 | $11.91 | 21% - 25% | 7,072 - 8,839 | 8,736 - 10,919 | 10,400 - 12,999 | 12,064 - 15,079 | 13,728 - 17,159 |
| $7.70 | $3.85 | $33.34 | $16.67 | 26% - 30% | 8,840 - 10,607 | 10,920 - 13,103 | 13,000 - 15,599 | 15,080 - 18,094 | 17,160 - 20,590 |
| $9.90 | $4.95 | $42.87 | $21.43 | 31% - 35% | 10,608 - 12,375 | 13,104 - 15,287 | 15,600 - 18,198 | 18,095 - 21,110 | 20,591 - 24,022 |
| $12.10 | $6.05 | $52.39 | $26.20 | 36% - 40% | 12,376 - 14,143 | 15,288 - 17,471 | 18,199 - 20,798 | 21,111 - 24,126 | 24,023 - 27,454 |
| $14.30 | $7.15 | $61.92 | $30.96 | 41% - 45% | 14,144 - 15,911 | 17,472 - 19,655 | 20,799 - 23,398 | 24,127 - 27,141 | 27,455 - 30,885 |
| $17.60 | $8.80 | $76.21 | $38.10 | 46% - 50% | 15,912 - 17,679 | 19,656 - 21,839 | 23,399 - 25,998 | 27,142 - 30,157 | 30,886 - 34,317 |
| $19.80 | $9.90 | $85.73 | $42.87 | 51% - 55% | 17,680 - 19,446 | 21,840 - 24,022 | 25,999 - 28,597 | 30,158 - 33,173 | 34,318 - 37,749 |
| $23.10 | $11.55 | $100.02 | $50.01 | 56% - 60% | 19,447 - 21,214 | 24,023 - 26,206 | 28,598 - 31,197 | 33,174 - 36,188 | 37,750 - 41,180 |
| $27.50 | $13.75 | $119.08 | $59.54 | 61% - 65% | 21,215 - 22,982 | 26,207 - 28,390 | 31,198 - 33,797 | 36,189 - 39,204 | 41,181 - 44,612 |
| $30.80 | $15.40 | $133.36 | $66.68 | 66% - 70% | 22,983 - 24,750 | 28,391 - 30,574 | 33,798 - 36,397 | 39,205 - 42,220 | 44,613 - 48,044 |
| $33.00 | $16.50 | $142.89 | $71.45 | 71% - 75% | 24,751 - 26,518 | 30,575 - 32,758 | 36,398 - 38,996 | 42,221 - 45,236 | 48,045 - 51,476 |

| Weekly Part-Time Co-Payment | | Monthly Part-Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 7 | 8 | 9 | 10 | 11 | 12 |
| $0.00 | $0.00 | $0.00 | $0.00 | 0% - 5% | 0 - 3,510 | 0 - 3,588 | 0 - 3,666 | 0 - 3,744 | 0 - 3,822 | 0 - 3,900 |
| $2.20 | $1.10 | $9.53 | $4.76 | 5% - 10% | 3,511 - 7,019 | 3,589 - 7,176 | 3,667 - 7,332 | 3,745 - 7,488 | 3,823 - 7,644 | 3,901 - 7,800 |
| $3.30 | $1.65 | $14.29 | $7.14 | 11% - 15% | 7,020 - 10,529 | 7,177 - 10,763 | 7,333 - 10,997 | 7,489 - 11,231 | 7,645 - 11,465 | 7,801 - 11,699 |
| $4.40 | $2.20 | $19.05 | $9.53 | 16% - 20% | 10,530 - 14,039 | 10,764 - 14,351 | 10,998 - 14,663 | 11,232 - 14,975 | 11,466 - 15,287 | 11,700 - 15,599 |
| $5.50 | $2.75 | $23.82 | $11.91 | 21% - 25% | 14,040 - 17,548 | 14,352 - 17,939 | 14,664 - 18,329 | 14,976 - 18,719 | 15,288 - 19,109 | 15,600 - 19,499 |
| $7.70 | $3.85 | $33.34 | $16.67 | 26% - 30% | 17,549 - 21,058 | 17,940 - 21,527 | 18,330 - 21,995 | 18,720 - 22,463 | 19,110 - 22,931 | 19,500 - 23,399 |
| $9.90 | $4.95 | $42.87 | $21.43 | 31% - 35% | 21,059 - 24,568 | 21,528 - 25,114 | 21,996 - 25,660 | 22,464 - 26,206 | 22,932 - 26,752 | 23,400 - 27,298 |
| $12.10 | $6.05 | $52.39 | $26.20 | 36% - 40% | 24,569 - 28,077 | 25,115 - 28,702 | 25,661 - 29,326 | 26,207 - 29,950 | 26,753 - 30,574 | 27,299 - 31,198 |
| $14.30 | $7.15 | $61.92 | $30.96 | 41% - 45% | 28,078 - 31,587 | 28,703 - 32,290 | 29,327 - 32,992 | 29,951 - 33,694 | 30,575 - 34,396 | 31,199 - 35,098 |
| $17.60 | $8.80 | $76.21 | $38.10 | 46% - 50% | 31,588 - 35,097 | 32,291 - 35,878 | 32,993 - 36,658 | 33,695 - 37,438 | 34,397 - 38,218 | 35,099 - 38,998 |
| $19.80 | $9.90 | $85.73 | $42.87 | 51% - 55% | 35,098 - 38,606 | 35,879 - 39,465 | 36,659 - 40,323 | 37,439 - 41,181 | 38,219 - 42,039 | 38,999 - 42,897 |
| $23.10 | $11.55 | $100.02 | $50.01 | 56% - 60% | 38,607 - 42,116 | 39,466 - 43,053 | 40,324 - 43,989 | 41,182 - 44,925 | 42,040 - 45,861 | 42,898 - 46,797 |
| $27.50 | $13.75 | $119.08 | $59.54 | 61% - 65% | 42,117 - 45,625 | 43,054 - 46,641 | 43,990 - 47,655 | 44,926 - 48,669 | 45,862 - 49,683 | 46,798 - 50,697 |
| $30.80 | $15.40 | $133.36 | $66.68 | 66% - 70% | 45,626 - 49,135 | 46,642 - 50,229 | 47,656 - 51,321 | 48,670 - 52,413 | 49,684 - 53,505 | 50,698 - 54,597 |
| $33.00 | $16.50 | $142.89 | $71.45 | 71% - 75% | 49,136 - 52,645 | 50,230 - 53,816 | 51,322 - 54,986 | 52,414 - 56,156 | 53,506 - 57,326 | 54,598 - 58,496 |

†Part-time care is defined as less than six (6) hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $.50 ($1.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.

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

10:81-14.18A REACH post-AFDC co-payment scale

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

(d) The co-payment scales are as follows:

1. (No change.)

2. Assessed co-payments are apportioned weekly and are due for the entire 52-week period that subsidized child care assistance is received. Holidays, emergency closings, and absences do not exclude or reduce the required fee co-payment.

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Table I
CHILD CARE CO-PAYMENT SCALE
FULL TIME CARE†

| Weekly Full Time Co-Payment | | Monthly Full Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income†††† | | | | |
|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 2 | 3 | 4 | 5 | 6 |
| $1.10 | $0.55 | $4.76 | $2.38 | 0% - 5% | 0 - 1,768 | 0 - 2,184 | 0 - 2,600 | 0 - 3,016 | 0 - 3,432 |
| $4.40 | $2.20 | $19.05 | $9.53 | 6% - 10% | 1,769 - 3,536 | 2,185 - 4,368 | 2,601 - 5,200 | 3,017 - 6,031 | 3,433 - 6,863 |
| $6.60 | $3.30 | $28.58 | $14.29 | 11% - 15% | 3,537 - 5,304 | 4,369 - 6,552 | 5,201 - 7,799 | 6,032 - 9,047 | 6,864 - 10,295 |
| $9.90 | $4.95 | $42.87 | $21.43 | 16% - 20% | 5,305 - 7,071 | 6,553 - 8,735 | 7,800 - 10,399 | 9,048 - 12,063 | 10,296 - 13,727 |
| $12.10 | $6.05 | $52.39 | $26.20 | 21% - 25% | 7,072 - 8,839 | 8,736 - 10,919 | 10,400 - 12,999 | 12,064 - 15,079 | 13,728 - 17,159 |
| $15.40 | $7.70 | $66.68 | $33.34 | 26% - 30% | 8,840 - 10,607 | 10,920 - 13,103 | 13,000 - 15,599 | 15,080 - 18,094 | 17,160 - 20,590 |
| $19.80 | $9.90 | $85.73 | $42.87 | 31% - 35% | 10,608 - 12,375 | 13,104 - 15,287 | 15,600 - 18,198 | 18,095 - 21,110 | 20,591 - 24,022 |
| $24.20 | $12.10 | $104.79 | $52.39 | 36% - 40% | 12,376 - 14,143 | 15,288 - 17,471 | 18,199 - 20,798 | 21,111 - 24,126 | 24,023 - 27,454 |
| $29.70 | $14.85 | $128.60 | $64.30 | 41% - 45% | 14,144 - 15,911 | 17,472 - 19,655 | 20,799 - 23,398 | 24,127 - 27,141 | 27,455 - 30,885 |
| $35.20 | $17.60 | $152.42 | $76.21 | 46% - 50% | 15,912 - 17,679 | 19,656 - 21,839 | 23,399 - 25,998 | 27,142 - 30,157 | 30,886 - 34,317 |
| $40.70 | $20.35 | $176.23 | $88.12 | 51% - 55% | 17,680 - 19,446 | 21,840 - 24,022 | 25,999 - 28,597 | 30,158 - 33,173 | 34,318 - 37,749 |
| $47.30 | $23.65 | $204.81 | $102.40 | 56% - 60% | 19,447 - 21,214 | 24,023 - 26,206 | 28,598 - 31,197 | 33,174 - 36,188 | 37,750 - 41,180 |
| $55.00 | $27.50 | $238.15 | $119.08 | 61% - 65% | 21,215 - 22,982 | 26,207 - 28,390 | 31,198 - 33,797 | 36,189 - 39,204 | 41,181 - 44,612 |
| $62.70 | $31.35 | $271.49 | $135.75 | 66% - 70% | 22,983 - 24,750 | 28,391 - 30,574 | 33,798 - 36,397 | 39,205 - 42,220 | 44,613 - 48,044 |
| $67.10 | $33.55 | $290.54 | $145.27 | 71% - 75% | 24,751 - 26,518 | 30,575 - 32,758 | 36,398 - 38,996 | 42,221 - 45,236 | 48,045 - 51,476 |

| Weekly Full Time Co-Payment | | Monthly Full Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 7 | 8 | 9 | 10 | 11 | 12 |
| $1.10 | $0.55 | $4.76 | $2.38 | 0% - 5% | 0 - 3,510 | 0 - 3,588 | 0 - 3,666 | 0 - 3,744 | 0 - 3,822 | 0 - 3,900 |
| $4.40 | $2.20 | $19.05 | $9.53 | 5% - 10% | 3,511 - 7,019 | 3,589 - 7,176 | 3,667 - 7,332 | 3,745 - 7,488 | 3,823 - 7,644 | 3,901 - 7,800 |
| $6.60 | $3.30 | $28.58 | $14.29 | 11% - 15% | 7,020 - 10,529 | 7,177 - 10,763 | 7,333 - 10,997 | 7,489 - 11,231 | 7,645 - 11,465 | 7,801 - 11,699 |
| $9.90 | $4.95 | $42.87 | $21.43 | 16% - 20% | 10,530 - 14,039 | 10,764 - 14,351 | 10,998 - 14,663 | 11,232 - 14,975 | 11,466 - 15,287 | 11,700 - 15,599 |
| $12.10 | $6.05 | $52.39 | $26.20 | 21% - 25% | 14,040 - 17,548 | 14,352 - 17,939 | 14,664 - 18,329 | 14,976 - 18,719 | 15,288 - 19,109 | 15,600 - 19,499 |
| $15.40 | $7.70 | $66.68 | $33.34 | 26% - 30% | 17,549 - 21,058 | 17,940 - 21,527 | 18,330 - 21,995 | 18,720 - 22,463 | 19,110 - 22,931 | 19,500 - 23,399 |
| $19.80 | $9.90 | $85.73 | $42.87 | 31% - 35% | 21,059 - 24,568 | 21,528 - 25,114 | 21,996 - 25,660 | 22,464 - 26,206 | 22,932 - 26,752 | 23,400 - 27,298 |
| $24.20 | $12.10 | $104.79 | $52.39 | 36% - 40% | 24,569 - 28,077 | 25,115 - 28,702 | 25,661 - 29,326 | 26,207 - 29,950 | 26,753 - 30,574 | 27,299 - 31,198 |
| $29.70 | $14.85 | $128.60 | $64.30 | 41% - 45% | 28,078 - 31,587 | 28,703 - 32,290 | 29,327 - 32,992 | 29,951 - 33,694 | 30,575 - 34,396 | 31,199 - 35,098 |
| $35.20 | $17.60 | $152.42 | $76.21 | 46% - 50% | 31,588 - 35,097 | 32,291 - 35,878 | 32,993 - 36,658 | 33,695 - 37,438 | 34,397 - 38,218 | 35,099 - 38,998 |
| $40.70 | $20.35 | $176.23 | $88.12 | 51% - 55% | 35,098 - 38,606 | 35,879 - 39,465 | 36,659 - 40,323 | 37,439 - 41,181 | 38,219 - 42,039 | 38,999 - 42,897 |
| $47.30 | $23.65 | $204.81 | $102.40 | 56% - 60% | 38,607 - 42,116 | 39,466 - 43,053 | 40,324 - 43,989 | 41,182 - 44,925 | 42,040 - 45,861 | 42,898 - 46,797 |
| $55.00 | $27.50 | $238.15 | $119.08 | 61% - 65% | 42,117 - 45,625 | 43,054 - 46,641 | 43,990 - 47,655 | 44,926 - 48,669 | 45,862 - 49,683 | 46,798 - 50,697 |
| $62.70 | $31.35 | $271.49 | $135.75 | 66% - 70% | 45,626 - 49,135 | 46,642 - 50,229 | 47,656 - 51,321 | 48,670 - 52,413 | 49,684 - 53,505 | 50,698 - 54,597 |
| $67.10 | $33.55 | $290.54 | $145.27 | 71% - 75% | 49,136 - 52,645 | 50,230 - 53,816 | 51,322 - 54,986 | 52,414 - 56,156 | 53,506 - 57,326 | 54,598 - 58,496 |

†Full time care is defined as six (6) or more hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $1.00 ($2.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.

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Table II
CHILD CARE CO-PAYMENT SCALE
PART-TIME CARE†

| Weekly Part-Time Co-Payment | | Monthly Part-Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income†††† | | | | |
|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 2 | 3 | 4 | 5 | 6 |
| $0.00 | $0.00 | $0.00 | $0.00 | 0% - 5% | 0 - 1,768 | 0 - 2,184 | 0 - 2,600 | 0 - 3,016 | 0 - 3,432 |
| $2.20 | $1.10 | $9.53 | $4.76 | 6% - 10% | 1,769 - 3,536 | 2,185 - 4,368 | 2,601 - 5,200 | 3,017 - 6,031 | 3,433 - 6,863 |
| $3.30 | $1.65 | $14.29 | $7.14 | 11% - 15% | 3,537 - 5,304 | 4,369 - 6,552 | 5,201 - 7,799 | 6,032 - 9,047 | 6,864 - 10,295 |
| $4.40 | $2.20 | $19.05 | $9.53 | 16% - 20% | 5,305 - 7,071 | 6,553 - 8,735 | 7,800 - 10,399 | 9,048 - 12,063 | 10,296 - 13,727 |
| $5.50 | $2.75 | $23.82 | $11.91 | 21% - 25% | 7,072 - 8,839 | 8,736 - 10,919 | 10,400 - 12,999 | 12,064 - 15,079 | 13,728 - 17,159 |
| $7.70 | $3.85 | $33.34 | $16.67 | 26% - 30% | 8,840 - 10,607 | 10,920 - 13,103 | 13,000 - 15,599 | 15,080 - 18,094 | 17,160 - 20,590 |
| $9.90 | $4.95 | $42.87 | $21.43 | 31% - 35% | 10,608 - 12,375 | 13,104 - 15,287 | 15,600 - 18,198 | 18,095 - 21,110 | 20,591 - 24,022 |
| $12.10 | $6.05 | $52.39 | $26.20 | 36% - 40% | 12,376 - 14,143 | 15,288 - 17,471 | 18,199 - 20,798 | 21,111 - 24,126 | 24,023 - 27,454 |
| $14.30 | $7.15 | $61.92 | $30.96 | 41% - 45% | 14,144 - 15,911 | 17,472 - 19,655 | 20,799 - 23,398 | 24,127 - 27,141 | 27,455 - 30,885 |
| $17.60 | $8.80 | $76.21 | $38.10 | 46% - 50% | 15,912 - 17,679 | 19,656 - 21,839 | 23,399 - 25,998 | 27,142 - 30,157 | 30,886 - 34,317 |
| $19.80 | $9.90 | $85.73 | $42.87 | 51% - 55% | 17,680 - 19,446 | 21,840 - 24,022 | 25,999 - 28,597 | 30,158 - 33,173 | 34,318 - 37,749 |
| $23.10 | $11.55 | $100.02 | $50.01 | 56% - 60% | 19,447 - 21,214 | 24,023 - 26,206 | 28,598 - 31,197 | 33,174 - 36,188 | 37,750 - 41,180 |
| $27.50 | $13.75 | $119.08 | $59.54 | 61% - 65% | 21,215 - 22,982 | 26,207 - 28,390 | 31,198 - 33,797 | 36,189 - 39,204 | 41,181 - 44,612 |
| $30.80 | $15.40 | $133.36 | $66.68 | 66% - 70% | 22,983 - 24,750 | 28,391 - 30,574 | 33,798 - 36,397 | 39,205 - 42,220 | 44,613 - 48,044 |
| $33.00 | $16.50 | $142.89 | $71.45 | 71% - 75% | 24,751 - 26,518 | 30,575 - 32,758 | 36,398 - 38,996 | 42,221 - 45,236 | 48,045 - 51,476 |

| Weekly Part-Time Co-Payment | | Monthly Part-Time Co-Payment††† | | Percent of State 1989 Median Family Income | Family Size and Annual Income | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 7 | 8 | 9 | 10 | 11 | 12 |
| $0.00 | $0.00 | $0.00 | $0.00 | 0% - 5% | 0 - 3,510 | 0 - 3,588 | 0 - 3,666 | 0 - 3,744 | 0 - 3,822 | 0 - 3,900 |
| $2.20 | $1.10 | $9.53 | $4.76 | 5% - 10% | 3,511 - 7,019 | 3,589 - 7,176 | 3,667 - 7,332 | 3,745 - 7,488 | 3,823 - 7,644 | 3,901 - 7,800 |
| $3.30 | $1.65 | $14.29 | $7.14 | 11% - 15% | 7,020 - 10,529 | 7,177 - 10,763 | 7,333 - 10,997 | 7,489 - 11,231 | 7,645 - 11,465 | 7,801 - 11,699 |
| $4.40 | $2.20 | $19.05 | $9.53 | 16% - 20% | 10,530 - 14,039 | 10,764 - 14,351 | 10,998 - 14,663 | 11,232 - 14,975 | 11,466 - 15,287 | 11,700 - 15,599 |
| $5.50 | $2.75 | $23.82 | $11.91 | 21% - 25% | 14,040 - 17,548 | 14,352 - 17,939 | 14,664 - 18,329 | 14,976 - 18,719 | 15,288 - 19,109 | 15,600 - 19,499 |
| $7.70 | $3.85 | $33.34 | $16.67 | 26% - 30% | 17,549 - 21,058 | 17,940 - 21,527 | 18,330 - 21,995 | 18,720 - 22,463 | 19,110 - 22,931 | 19,500 - 23,399 |
| $9.90 | $4.95 | $42.87 | $21.43 | 31% - 35% | 21,059 - 24,568 | 21,528 - 25,114 | 21,996 - 25,660 | 22,464 - 26,206 | 22,932 - 26,752 | 23,400 - 27,298 |
| $12.10 | $6.05 | $52.39 | $26.20 | 36% - 40% | 24,569 - 28,077 | 25,115 - 28,702 | 25,661 - 29,326 | 26,207 - 29,950 | 26,753 - 30,574 | 27,299 - 31,198 |
| $14.30 | $7.15 | $61.92 | $30.96 | 41% - 45% | 28,078 - 31,587 | 28,703 - 32,290 | 29,327 - 32,992 | 29,951 - 33,694 | 30,575 - 34,396 | 31,199 - 35,098 |
| $17.60 | $8.80 | $76.21 | $38.10 | 46% - 50% | 31,588 - 35,097 | 32,291 - 35,878 | 32,993 - 36,658 | 33,695 - 37,438 | 34,397 - 38,218 | 35,099 - 38,998 |
| $19.80 | $9.90 | $85.73 | $42.87 | 51% - 55% | 35,098 - 38,606 | 35,879 - 39,465 | 36,659 - 40,323 | 37,439 - 41,181 | 38,219 - 42,039 | 38,999 - 42,897 |
| $23.10 | $11.55 | $100.02 | $50.01 | 56% - 60% | 38,607 - 42,116 | 39,466 - 43,053 | 40,324 - 43,989 | 41,182 - 44,925 | 42,040 - 45,861 | 42,898 - 46,797 |
| $27.50 | $13.75 | $119.08 | $59.54 | 61% - 65% | 42,117 - 45,625 | 43,054 - 46,641 | 43,990 - 47,655 | 44,926 - 48,669 | 45,862 - 49,683 | 46,798 - 50,697 |
| $30.80 | $15.40 | $133.36 | $66.68 | 66% - 70% | 45,626 - 49,135 | 46,642 - 50,229 | 47,656 - 51,321 | 48,670 - 52,413 | 49,684 - 53,505 | 50,698 - 54,597 |
| $33.00 | $16.50 | $142.89 | $71.45 | 71% - 75% | 49,136 - 52,645 | 50,230 - 53,816 | 51,322 - 54,986 | 52,414 - 56,156 | 53,506 - 57,326 | 54,598 - 58,496 |

†Part-time care is defined as less than six (6) hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $.50 ($1.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.

(e)-(h) (No change.)

10:82-5.3 Payment for child care through Title IV-A funds

(a)-(f) (No change.)

(g) Statewide maximum child care payment rates are based upon either the age or special needs status of the child and on the number of hours of care provided in the various types of child care arrangements. Included in the types of arrangements are registered homes, approved homes, in-home care, child care centers and day camps, and the hours of care provided (that is, full and part-time day care and care before and after school and during school recesses).

1.-4. (No change.)

5. The maximum authorized rates for child care are set forth in Tables I, II and III below, as determined by the type of child care arrangements, and based upon either the age or special needs status of the child and the hours of care provided.

IV-A CHILD CARE MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

HOURS OF CARE PROVIDED

| Child's Service Category: | Full-Time 6 hrs. or more per day | Three-Quarter Time† 4 or 5 hrs. per day | One-Half Time† 2 or 3 hrs. per day | One-Quarter Time† 1 hr. per day |
|---|---|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $116.20 | $87.15 | $58.10 | $29.05 |
| Daily | $ 23.24 | $17.43 | $11.62 | $ 5.81 |

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| | | | | |
|---|---|---|---|---|
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $116.20 | $87.15 | $58.10 | $29.05 |
| Daily | $ 23.24 | $17.43 | $11.62 | $ 5.81 |
| Pre-Schoolers (2.5 up to 5 yrs.) | | | | |
| Weekly | $ 95.80 | $71.85 | $47.90 | $23.95 |
| Daily | $ 19.16 | $14.37 | $ 9.58 | $ 4.79 |
| Kindergartners & School-Agers (5-13 yrs.) | | | | |
| Weekly | $ 95.80 | $71.85 | $47.90 | $23.95 |
| Daily | $ 19.16 | $14.37 | $ 9.58 | $ 4.79 |
| Special Needs Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $116.20 | $87.15 | $58.10 | $29.05 |
| Daily | $ 23.24 | $17.43 | $11.62 | $ 5.81 |
| Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $116.20 | $87.15 | $58.10 | $29.05 |
| Daily | $ 23.24 | $17.43 | $11.62 | $ 5.81 |
| Special Needs Child(ren) (2.5 up to 19 yrs.) | | | | |
| Weekly | $ 95.80 | $71.85 | $47.90 | $23.95 |
| Daily | $ 19.16 | $14.37 | $ 9.58 | $ 4.79 |

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.

IV-A CHILD CARE MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

HOURS OF CARE PROVIDED

| Child's Service Category: | Full-Time 6 hrs. or more per day | Three-Quarter Time† 4 or 5 hrs. per day | One-Half Time† 2 or 3 hrs. per day | One-Quarter Time† 1 hr. per day |
|---|---|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $ 91.80 | $68.85 | $45.90 | $22.95 |
| Daily | $ 18.36 | $13.77 | $ 9.18 | $ 4.59 |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $ 91.80 | $68.85 | $45.90 | $22.95 |
| Daily | $ 18.36 | $13.77 | $ 9.18 | $ 4.59 |
| Pre-Schoolers (2.5 up to 5 yrs.) | | | | |
| Weekly | $ 71.40 | $53.55 | $35.70 | $17.85 |
| Daily | $ 14.28 | $10.71 | $ 7.14 | $ 3.57 |
| Kindergartners & School-Agers (5-13 yrs.) | | | | |
| Weekly | $ 71.40 | $53.55 | $35.70 | $17.85 |
| Daily | $ 14.28 | $10.71 | $ 7.14 | $ 3.57 |
| Special Needs Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $112.20 | $84.15 | $56.10 | $28.05 |
| Daily | $ 22.44 | $16.83 | $11.22 | $ 5.61 |
| Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $112.20 | $84.15 | $56.10 | $28.05 |
| Daily | $ 22.44 | $16.83 | $11.22 | $ 5.61 |
| Special Needs Child(ren) (2.5 up to 19 yrs.) | | | | |
| Weekly | $ 91.80 | $68.85 | $45.90 | $22.95 |
| Daily | $ 18.36 | $13.77 | $ 9.18 | $ 4.59 |

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.

IV-A CHILD CARE MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

HOURS OF CARE PROVIDED

| Child's Service Category: | Full-Time 6 hrs. or more per day | Three-Quarter Time† 4 or 5 hrs. per day | One-Half Time† 2 or 3 hrs. per day | One-Quarter Time† 1 hr. per day |
|---|---|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $55.10 | $41.30 | $27.55 | $13.75 |
| Daily | $11.02 | $ 8.26 | $ 5.51 | $ 2.75 |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $55.10 | $41.30 | $27.55 | $13.75 |
| Daily | $11.02 | $ 8.26 | $ 5.51 | $ 2.75 |
| Pre-Schoolers (2.5 up to 5 yrs.) | | | | |
| Weekly | $42.80 | $32.10 | $21.40 | $10.70 |
| Daily | $ 8.56 | $ 6.42 | $ 4.28 | $ 2.14 |
| Kindergartners & School-Agers (5-13 yrs.) | | | | |
| Weekly | $42.80 | $32.10 | $21.40 | $10.70 |
| Daily | $ 8.56 | $ 6.42 | $ 4.28 | $ 2.14 |
| Special Needs Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $67.30 | $50.50 | $33.65 | $16.80 |
| Daily | $13.46 | $10.10 | $ 6.73 | $ 3.36 |
| Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $67.30 | $50.50 | $33.65 | $16.80 |
| Daily | $13.46 | $10.10 | $ 6.73 | $ 3.36 |
| Special Needs Child(ren) (2.5 up to 19 yrs.) | | | | |
| Weekly | $55.10 | $41.30 | $27.55 | $13.75 |
| Daily | $11.02 | $ 8.26 | $ 5.51 | $ 2.75 |

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.

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(h) (No change.)

10:86-10.2 Types of care and duration of child care payments

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

(d) The maximum child care payment rates, set forth in Tables I, II and III below, specify weekly and daily rates for the various age categories of children based on the hours of care provided.

1.-3. (No change.)

FDP CHILD CARE MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

HOURS OF CARE PROVIDED

| Child's Service Category: | Full-Time 6 hrs. or more per day | Three-Quarter Time† 4 or 5 hrs. per day | One-Half Time† 2 or 3 hrs. per day | One-Quarter Time† 1 hr. per day |
|---|---|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $116.20 | $87.15 | $58.10 | $29.05 |
| Daily | $ 23.24 | $17.43 | $11.62 | $ 5.81 |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $116.20 | $87.15 | $58.10 | $29.05 |
| Daily | $ 23.24 | $17.43 | $11.62 | $ 5.81 |
| Pre-Schoolers (2.5 up to 5 yrs.) | | | | |
| Weekly | $ 95.80 | $71.85 | $47.90 | $23.95 |
| Daily | $ 19.16 | $14.37 | $ 9.58 | $ 4.79 |
| Kindergartners & School-Agers (5-13 yrs.) | | | | |
| Weekly | $ 95.80 | $71.85 | $47.90 | $23.95 |
| Daily | $ 19.16 | $14.37 | $ 9.58 | $ 4.79 |
| Special Needs Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $116.20 | $87.15 | $58.10 | $29.05 |
| Daily | $ 23.24 | $17.43 | $11.62 | $ 5.81 |
| Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $116.20 | $87.15 | $58.10 | $29.05 |
| Daily | $ 23.24 | $17.43 | $11.62 | $ 5.81 |
| Special Needs Child(ren) (2.5 up to 19 yrs.) | | | | |
| Weekly | $ 95.80 | $71.85 | $47.90 | $23.95 |
| Daily | $ 19.16 | $14.37 | $ 9.58 | $ 4.79 |

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.

FDP CHILD CARE MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

HOURS OF CARE PROVIDED

| Child's Service Category: | Full-Time 6 hrs. or more per day | Three-Quarter Time† 4 or 5 hrs. per day | One-Half Time† 2 or 3 hrs. per day | One-Quarter Time† 1 hr. per day |
|---|---|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $ 91.80 | $68.85 | $45.90 | $22.95 |
| Daily | $ 18.36 | $13.77 | $ 9.18 | $ 4.59 |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $ 91.80 | $68.85 | $45.90 | $22.95 |
| Daily | $ 18.36 | $13.77 | $ 9.18 | $ 4.59 |
| Pre-Schoolers (2.5 up to 5 yrs.) | | | | |
| Weekly | $ 71.40 | $53.55 | $35.70 | $17.85 |
| Daily | $ 14.28 | $10.71 | $ 7.14 | $ 3.57 |
| Kindergartners & School-Agers (5 up to 13 yrs.) | | | | |
| Weekly | $ 71.40 | $53.55 | $35.70 | $17.85 |
| Daily | $ 14.28 | $10.71 | $ 7.14 | $ 3.57 |
| Special Needs Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $112.20 | $84.15 | $56.10 | $28.05 |
| Daily | $ 22.44 | $16.83 | $11.22 | $ 5.61 |
| Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $112.20 | $84.15 | $56.10 | $28.05 |
| Daily | $ 22.44 | $16.83 | $11.22 | $ 5.61 |
| Special Needs Child(ren) (2.5 up to 19 yrs.) | | | | |
| Weekly | $ 91.80 | $68.85 | $45.90 | $22.95 |
| Daily | $ 18.36 | $13.77 | $ 9.18 | $ 4.59 |

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.

FDP CHILD CARE MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

HOURS OF CARE PROVIDED

| Child's Service Category: | Full-Time 6 hrs. or more per day | Three-Quarter Time† 4 or 5 hrs. per day | One-Half Time† 2 or 3 hrs. per day | One-Quarter Time† 1 hr. per day |
|---|---|---|---|---|
| Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $55.10 | $41.30 | $27.55 | $13.75 |
| Daily | $11.02 | $ 8.26 | $ 5.51 | $ 2.75 |
| Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $55.10 | $41.30 | $27.55 | $13.75 |
| Daily | $11.02 | $ 8.26 | $ 5.51 | $ 2.75 |

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| | | | | |
|---|---|---|---|---|
| Pre-Schoolers (2.5 up to 5 yrs.) | | | | |
| Weekly | $42.80 | $32.10 | $21.40 | $10.70 |
| Daily | $ 8.56 | $ 6.42 | $ 4.28 | $ 2.14 |
| Kindergartners & School-Agers (5 up to 13 yrs.) | | | | |
| Weekly | $42.80 | $32.10 | $21.40 | $10.70 |
| Daily | $ 8.56 | $ 6.42 | $ 4.28 | $ 2.14 |
| Special Needs Infants/Toddlers (0 up to 2 yrs.) | | | | |
| Weekly | $67.30 | $50.50 | $33.65 | $16.80 |
| Daily | $13.46 | $10.10 | $ 6.73 | $ 3.36 |
| Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.) | | | | |
| Weekly | $67.30 | $50.50 | $33.65 | $16.80 |
| Daily | $13.46 | $10.10 | $ 6.73 | $ 3.36 |
| Special Needs Child(ren) (2.5 up to 19 yrs.) | | | | |
| Weekly | $55.10 | $41.30 | $27.55 | $13.75 |
| Daily | $11.02 | $ 8.26 | $ 5.51 | $ 2.75 |

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.

Table I
CHILD CARE CO-PAYMENT SCALE
FULL TIME CARE†

| Weekly Full Time Co-Payment | | Monthly Full Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income†††† | | | | |
|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 2 | 3 | 4 | 5 | 6 |
| $1.10 | $0.55 | $4.76 | $2.38 | 0% - 5% | 0 - 1,768 | 0 - 2,184 | 0 - 2,600 | 0 - 3,016 | 0 - 3,432 |
| $4.40 | $2.20 | $19.05 | $9.53 | 6% - 10% | 1,769 - 3,536 | 2,185 - 4,368 | 2,601 - 5,200 | 3,017 - 6,031 | 3,433 - 6,863 |
| $6.60 | $3.30 | $28.58 | $14.29 | 11% - 15% | 3,537 - 5,304 | 4,369 - 6,552 | 5,201 - 7,799 | 6,032 - 9,047 | 6,864 - 10,295 |
| $9.90 | $4.95 | $42.87 | $21.43 | 16% - 20% | 5,305 - 7,071 | 6,553 - 8,735 | 7,800 - 10,399 | 9,048 - 12,063 | 10,296 - 13,727 |
| $12.10 | $6.05 | $52.39 | $26.20 | 21% - 25% | 7,072 - 8,839 | 8,736 - 10,919 | 10,400 - 12,999 | 12,064 - 15,079 | 13,728 - 17,159 |
| $15.40 | $7.70 | $66.68 | $33.34 | 26% - 30% | 8,840 - 10,607 | 10,920 - 13,103 | 13,000 - 15,599 | 15,080 - 18,094 | 17,160 - 20,590 |
| $19.80 | $9.90 | $85.73 | $42.87 | 31% - 35% | 10,608 - 12,375 | 13,104 - 15,287 | 15,600 - 18,198 | 18,095 - 21,110 | 20,591 - 24,022 |
| $24.20 | $12.10 | $104.79 | $52.39 | 36% - 40% | 12,376 - 14,143 | 15,288 - 17,471 | 18,199 - 20,798 | 21,111 - 24,126 | 24,023 - 27,454 |
| $29.70 | $14.85 | $128.60 | $64.30 | 41% - 45% | 14,144 - 15,911 | 17,472 - 19,655 | 20,799 - 23,398 | 24,127 - 27,141 | 27,455 - 30,885 |
| $35.20 | $17.60 | $152.42 | $76.21 | 46% - 50% | 15,912 - 17,679 | 19,656 - 21,839 | 23,399 - 25,998 | 27,142 - 30,157 | 30,886 - 34,317 |
| $40.70 | $20.35 | $176.23 | $88.12 | 51% - 55% | 17,680 - 19,446 | 21,840 - 24,022 | 25,999 - 28,597 | 30,158 - 33,173 | 34,318 - 37,749 |
| $47.30 | $23.65 | $204.81 | $102.40 | 56% - 60% | 19,447 - 21,214 | 24,023 - 26,206 | 28,598 - 31,197 | 33,174 - 36,188 | 37,750 - 41,180 |
| $55.00 | $27.50 | $238.15 | $119.08 | 61% - 65% | 21,215 - 22,982 | 26,207 - 28,390 | 31,198 - 33,797 | 36,189 - 39,204 | 41,181 - 44,612 |
| $62.70 | $31.35 | $271.49 | $135.75 | 66% - 70% | 22,983 - 24,750 | 28,391 - 30,574 | 33,798 - 36,397 | 39,205 - 42,220 | 44,613 - 48,044 |
| $67.10 | $33.55 | $290.54 | $145.27 | 71% - 75% | 24,751 - 26,518 | 30,575 - 32,758 | 36,398 - 38,996 | 42,221 - 45,236 | 48,045 - 51,476 |

| Weekly Full Time Co-Payment | | Monthly Full Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 7 | 8 | 9 | 10 | 11 | 12 |
| $1.10 | $0.55 | $4.76 | $2.38 | 0% - 5% | 0 - 3,510 | 0 - 3,588 | 0 - 3,666 | 0 - 3,744 | 0 - 3,822 | 0 - 3,900 |
| $4.40 | $2.20 | $19.05 | $9.53 | 5% - 10% | 3,511 - 7,019 | 3,589 - 7,176 | 3,667 - 7,332 | 3,745 - 7,488 | 3,823 - 7,644 | 3,901 - 7,800 |
| $6.60 | $3.30 | $28.58 | $14.29 | 11% - 15% | 7,020 - 10,529 | 7,177 - 10,763 | 7,333 - 10,997 | 7,489 - 11,231 | 7,645 - 11,465 | 7,801 - 11,699 |
| $9.90 | $4.95 | $42.87 | $21.43 | 16% - 20% | 10,530 - 14,039 | 10,764 - 14,351 | 10,998 - 14,663 | 11,232 - 14,975 | 11,466 - 15,287 | 11,700 - 15,599 |
| $12.10 | $6.05 | $52.39 | $26.20 | 21% - 25% | 14,040 - 17,548 | 14,352 - 17,939 | 14,664 - 18,329 | 14,976 - 18,719 | 15,288 - 19,109 | 15,600 - 19,499 |
| $15.40 | $7.70 | $66.68 | $33.34 | 26% - 30% | 17,549 - 21,058 | 17,940 - 21,527 | 18,330 - 21,995 | 18,720 - 22,463 | 19,110 - 22,931 | 19,500 - 23,399 |
| $19.80 | $9.90 | $85.73 | $42.87 | 31% - 35% | 21,059 - 24,568 | 21,528 - 25,114 | 21,996 - 25,660 | 22,464 - 26,206 | 22,932 - 26,752 | 23,400 - 27,298 |
| $24.20 | $12.10 | $104.79 | $52.39 | 36% - 40% | 24,569 - 28,077 | 25,115 - 28,702 | 25,661 - 29,326 | 26,207 - 29,950 | 26,753 - 30,574 | 27,299 - 31,198 |
| $29.70 | $14.85 | $128.60 | $64.30 | 41% - 45% | 28,078 - 31,587 | 28,703 - 32,290 | 29,327 - 32,992 | 29,951 - 33,694 | 30,575 - 34,396 | 31,199 - 35,098 |
| $35.20 | $17.60 | $152.42 | $76.21 | 46% - 50% | 31,588 - 35,097 | 32,291 - 35,878 | 32,993 - 36,658 | 33,695 - 37,438 | 34,397 - 38,218 | 35,099 - 38,998 |
| $40.70 | $20.35 | $176.23 | $88.12 | 51% - 55% | 35,098 - 38,606 | 35,879 - 39,465 | 36,659 - 40,323 | 37,439 - 41,181 | 38,219 - 42,039 | 38,999 - 42,897 |
| $47.30 | $23.65 | $204.81 | $102.40 | 56% - 60% | 38,607 - 42,116 | 39,466 - 43,053 | 40,324 - 43,989 | 41,182 - 44,925 | 42,040 - 45,861 | 42,898 - 46,797 |
| $55.00 | $27.50 | $238.15 | $119.08 | 61% - 65% | 42,117 - 45,625 | 43,054 - 46,641 | 43,990 - 47,655 | 44,926 - 48,669 | 45,862 - 49,683 | 46,798 - 50,697 |
| $62.70 | $31.35 | $271.49 | $135.75 | 66% - 70% | 45,626 - 49,135 | 46,642 - 50,229 | 47,656 - 51,321 | 48,670 - 52,413 | 49,684 - 53,505 | 50,698 - 54,597 |
| $67.10 | $33.55 | $290.54 | $145.27 | 71% - 75% | 49,136 - 52,645 | 50,230 - 53,816 | 51,322 - 54,986 | 52,414 - 56,156 | 53,506 - 57,326 | 54,598 - 58,496 |

†Full time care is defined as six (6) or more hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $1.00 ($2.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.

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Table II
CHILD CARE CO-PAYMENT SCALE
PART-TIME CARE†

| Weekly Part-Time Co-Payment | | Monthly Part-Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income†††† | | | | |
|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 2 | 3 | 4 | 5 | 6 |
| $0.00 | $0.00 | $0.00 | $0.00 | 0% - 5% | 0 - 1,768 | 0 - 2,184 | 0 - 2,600 | 0 - 3,016 | 0 - 3,432 |
| $2.20 | $1.10 | $9.53 | $4.76 | 6% - 10% | 1,769 - 3,536 | 2,185 - 4,368 | 2,601 - 5,200 | 3,017 - 6,031 | 3,433 - 6,863 |
| $3.30 | $1.65 | $14.29 | $7.14 | 11% - 15% | 3,537 - 5,304 | 4,369 - 6,552 | 5,201 - 7,799 | 6,032 - 9,047 | 6,864 - 10,295 |
| $4.40 | $2.20 | $19.05 | $9.53 | 16% - 20% | 5,305 - 7,071 | 6,553 - 8,735 | 7,800 - 10,399 | 9,048 - 12,063 | 10,296 - 13,727 |
| $5.50 | $2.75 | $23.82 | $11.91 | 21% - 25% | 7,072 - 8,839 | 8,736 - 10,919 | 10,400 - 12,999 | 12,064 - 15,079 | 13,728 - 17,159 |
| $7.70 | $3.85 | $33.34 | $16.67 | 26% - 30% | 8,840 - 10,607 | 10,920 - 13,103 | 13,000 - 15,599 | 15,080 - 18,094 | 17,160 - 20,590 |
| $9.90 | $4.95 | $42.87 | $21.43 | 31% - 35% | 10,608 - 12,375 | 13,104 - 15,287 | 15,600 - 18,198 | 18,095 - 21,110 | 20,591 - 24,022 |
| $12.10 | $6.05 | $52.39 | $26.20 | 36% - 40% | 12,376 - 14,143 | 15,288 - 17,471 | 18,199 - 20,798 | 21,111 - 24,126 | 24,023 - 27,454 |
| $14.30 | $7.15 | $61.92 | $30.96 | 41% - 45% | 14,144 - 15,911 | 17,472 - 19,655 | 20,799 - 23,398 | 24,127 - 27,141 | 27,455 - 30,885 |
| $17.60 | $8.80 | $76.21 | $38.10 | 46% - 50% | 15,912 - 17,679 | 19,656 - 21,839 | 23,399 - 25,998 | 27,142 - 30,157 | 30,886 - 34,317 |
| $19.80 | $9.90 | $85.73 | $42.87 | 51% - 55% | 17,680 - 19,446 | 21,840 - 24,022 | 25,999 - 28,597 | 30,158 - 33,173 | 34,318 - 37,749 |
| $23.10 | $11.55 | $100.02 | $50.01 | 56% - 60% | 19,447 - 21,214 | 24,023 - 26,206 | 28,598 - 31,197 | 33,174 - 36,188 | 37,750 - 41,180 |
| $27.50 | $13.75 | $119.08 | $59.54 | 61% - 65% | 21,215 - 22,982 | 26,207 - 28,390 | 31,198 - 33,797 | 36,189 - 39,204 | 41,181 - 44,612 |
| $30.80 | $15.40 | $133.36 | $66.68 | 66% - 70% | 22,983 - 24,750 | 28,391 - 30,574 | 33,798 - 36,397 | 39,205 - 42,220 | 44,613 - 48,044 |
| $33.00 | $16.50 | $142.89 | $71.45 | 71% - 75% | 24,751 - 26,518 | 30,575 - 32,758 | 36,398 - 38,996 | 42,221 - 45,236 | 48,045 - 51,476 |

| Weekly Part-Time Co-Payment | | Monthly Part-Time Co-Payment†† | | Percent of State 1989 Median Family Income | Family Size and Annual Income | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First Child | Second Child††† | First Child | Second Child††† | | 7 | 8 | 9 | 10 | 11 | 12 |
| $0.00 | $0.00 | $0.00 | $0.00 | 0% - 5% | 0 - 3,510 | 0 - 3,588 | 0 - 3,666 | 0 - 3,744 | 0 - 3,822 | 0 - 3,900 |
| $2.20 | $1.10 | $9.53 | $4.76 | 5% - 10% | 3,511 - 7,019 | 3,589 - 7,176 | 3,667 - 7,332 | 3,745 - 7,488 | 3,823 - 7,644 | 3,901 - 7,800 |
| $3.30 | $1.65 | $14.29 | $7.14 | 11% - 15% | 7,020 - 10,529 | 7,177 - 10,763 | 7,333 - 10,997 | 7,489 - 11,231 | 7,645 - 11,465 | 7,801 - 11,699 |
| $4.40 | $2.20 | $19.05 | $9.53 | 16% - 20% | 10,530 - 14,039 | 10,764 - 14,351 | 10,998 - 14,663 | 11,232 - 14,975 | 11,466 - 15,287 | 11,700 - 15,599 |
| $5.50 | $2.75 | $23.82 | $11.91 | 21% - 25% | 14,040 - 17,548 | 14,352 - 17,939 | 14,664 - 18,329 | 14,976 - 18,719 | 15,288 - 19,109 | 15,600 - 19,499 |
| $7.70 | $3.85 | $33.34 | $16.67 | 26% - 30% | 17,549 - 21,058 | 17,940 - 21,527 | 18,330 - 21,995 | 18,720 - 22,463 | 19,110 - 22,931 | 19,500 - 23,399 |
| $9.90 | $4.95 | $42.87 | $21.43 | 31% - 35% | 21,059 - 24,568 | 21,528 - 25,114 | 21,996 - 25,660 | 22,464 - 26,206 | 22,932 - 26,752 | 23,400 - 27,298 |
| $12.10 | $6.05 | $52.39 | $26.20 | 36% - 40% | 24,569 - 28,077 | 25,115 - 28,702 | 25,661 - 29,326 | 26,207 - 29,950 | 26,753 - 30,574 | 27,299 - 31,198 |
| $14.30 | $7.15 | $61.92 | $30.96 | 41% - 45% | 28,078 - 31,587 | 28,703 - 32,290 | 29,327 - 32,992 | 29,951 - 33,694 | 30,575 - 34,396 | 31,199 - 35,098 |
| $17.60 | $8.80 | $76.21 | $38.10 | 46% - 50% | 31,588 - 35,097 | 32,291 - 35,878 | 32,993 - 36,658 | 33,695 - 37,438 | 34,397 - 38,218 | 35,099 - 38,998 |
| $19.80 | $9.90 | $85.73 | $42.87 | 51% - 55% | 35,098 - 38,606 | 35,879 - 39,465 | 36,659 - 40,323 | 37,439 - 41,181 | 38,219 - 42,039 | 38,999 - 42,897 |
| $23.10 | $11.55 | $100.02 | $50.01 | 56% - 60% | 38,607 - 42,116 | 39,466 - 43,053 | 40,324 - 43,989 | 41,182 - 44,925 | 42,040 - 45,861 | 42,898 - 46,797 |
| $27.50 | $13.75 | $119.08 | $59.54 | 61% - 65% | 42,117 - 45,625 | 43,054 - 46,641 | 43,990 - 47,655 | 44,926 - 48,669 | 45,862 - 49,683 | 46,798 - 50,697 |
| $30.80 | $15.40 | $133.36 | $66.68 | 66% - 70% | 45,626 - 49,135 | 46,642 - 50,229 | 47,656 - 51,321 | 48,670 - 52,413 | 49,684 - 53,505 | 50,698 - 54,597 |
| $33.00 | $16.50 | $142.89 | $71.45 | 71% - 75% | 49,136 - 52,645 | 50,230 - 53,816 | 51,322 - 54,986 | 52,414 - 56,156 | 53,506 - 57,326 | 54,598 - 58,496 |

†Part-time care is defined as less than six (6) hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $.50 ($1.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.

(c)-(f) (No change.)

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## (a)

## DIVISION OF MENTAL HEALTH AND HOSPITALS

### Quality Assurance, Site Review Standards and Certification Process

### Adopted New Rules: N.J.A.C. 10:37-9 and 10
### Adopted Repeals: N.J.A.C. 10:37-6.62 through 6.72, and 6.92 through 6.98

Proposed: June 7, 1993 at 25 N.J.R. 2193(a).
Adopted: July 26, 1993 by William Waldman, Commissioner, Department of Human Services.
Filed: July 26, 1993 as R.1993 d.412, **with a technical change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:9A-10.
Effective Date: August 16, 1993.
Expiration Date: November 2, 1995.

**Summary** of Public Comments and Agency Responses:
**No comments were received.**

**Full text** of the adoption follows (addition to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 9. QUALITY ASSURANCE

10:37-9.1 Introduction

(a) The rules within this subchapter are designed and intended to provide a framework for provider agencies (PAs) to use when developing a quality assurance (QA) program. The standards set

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forth in this subchapter require PAs to implement a process of ongoing monitoring and evaluation, through the following activities:

1. Development of a written QA plan;
2. Description of how the plan is to be implemented;
3. Identification of important components of all QA programs;
4. Follow-up on problems or opportunities to improve care identified through QA activities; and
5. Evaluation of the impact of the QA program.

(b) The rules do not delineate specific aspects of care to be monitored. These shall be established by each PA, based on the individual PA's mission, goals and objectives.

(c) Additional QA standards specific to particular program elements may also be included in program element rules throughout this chapter.

10:37-9.2 Scope and purpose

(a) This subchapter applies to PAs as defined in N.J.A.C. 10:37-9.3.

(b) PAs shall implement a QA program which provides an ongoing loop of information about important aspects of care.

(c) The standards set forth in this subchapter, when implemented, shall provide PAs with information about their ability to provide responsive, outcome oriented treatment to clients by generating data about the following:

1. Whether clients receive services appropriate to their needs;
2. Whether clients are attaining individual program goals;
3. Whether programming is flexible enough to meet the changing needs of clients;
4. Whether clients are receiving the services that are documented on their treatment plans;
5. Whether clients are receiving services they do not need;
6. Whether clients are receiving services they want;
7. Whether clients are staying in service for an appropriate period of time, commensurate with their needs;
8. Whether there is client participation in treatment and in evaluating the quality of service; and
9. Whether staff are qualified to provide particular services to clients and whether their skills are enhanced through continuing education.

10:37-9.3 Definitions

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

"Adverse medication reactions" means any response to a drug that is unintended, occurring at doses used for prophylaxis, diagnosis or therapy, which demonstrates a deviation from the expected pharmaceutical, therapeutic or chemical action of the drug. Minor adverse medication reactions result in a need for an antidote or therapy. Moderate adverse medication reactions require a change in drug therapy and/or specific treatment. Severe adverse medication reactions are potentially life threatening, cause permanent damage or require intensive medical care.

"Appropriate(ness)" means the right treatment in the right amount/frequency, to the right patient at the right time by the right staff performed the right way.

"Division" means the Division of Mental Health and Hospitals.

"Drug usage evaluation" means a criteria-based, ongoing, planned and systematic process for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to assure that they are provided appropriately, safely and effectively.

"Follow-up" means reassessment of a problem at an appropriate interval to determine whether proposed solutions have been implemented and have remained effective.

"High risk" means any activity or intervention that could result in serious consequences or could deprive clients of substantial benefit, including providing care that is not indicated, or failing to provide care that is indicated.

"High volume" means an aspect of care which occurs frequently or affects large numbers of clients.

"Incident" means an unexpected event that places a client(s) or staff member(s) at risk.

"Indicator" means a defined, measurable, objective dimension of the quality and appropriateness of care which is based on current knowledge and clinical experience. Indicators are structures of care (for example, resources), processes of care (for example, procedures, techniques), or outcomes of care (for example, failure to improve).

"Infection control" means a program that includes the surveillance, prevention and control of infections.

"Justification for continued service(s)" means a determination, based on objective clinical criteria, that a client continues to require a specific service(s) or level of care.

"Length of stay review" means the point in treatment, on a timeline, at which a case should be reviewed to determine that the clinical neeeds of the client are being met and that proper utilization of resources is occurring.

"Life safety" means structures and activities related to provision of a safe, secure physical environment.

"Problem prone" means an aspect of care that has tended, in the past, to produce problems for clients and/or staff.

"Provider agency (PA)" means an agency contracted with, or funded by, the Division to provide specific, direct mental health services to clients.

"Quality assurance (QA)" means a program or set of activities designed to monitor, evaluate and improve care or services provided in order to enhance the health of clients and the effective use of resources.

"Quantitative review" means a review of a clinical record for timely completion of required documentation.

"QA oversight" means the function of ensuring implementation of the QA program and resolution of identified issues, but not necessarily carrying out monitoring and evaluation activities or corrective actions. This can be done by an existing committee or a separate committee established specifically for this purpose.

"Representative sample" means a selected subset of a larger group which exemplifies the characteristics of that group (that is, a cross-section).

"Risk management" means clinical and administrative activities designed to detect, prevent or reduce risks that could impair client care or client, staff or visitor comfort or safety.

"Routine/ongoing monitoring" means collecting and organizing data continuously according to a predetermined frequency; to check or observe.

"Sample size" means a number of cases or observations selected from a population for a specific sample (that is, a subset).

"Special case review" means clinical evaluation of and recommendations about the treatment of a difficult or high risk case by practicing mental health professionals (peers, supervisors, consultants) to the treating mental health professional(s).

"Thresholds for evaluation" means a pre-established level (number, percentage or proportion) in cumulative data that will trigger more intensive evaluation to determine whether an actual problem or opportunity to improve care exists (for example, 90 percent, one half, two out of six).

"Trend" means a recognizable pattern of occurrences; a straight line or other statistical curve showing the tendency of some function to increase or decrease over a period of time.

"Utilization review (UR)" means the process of using predefined criteria to evaluate the necessity of admissions and continued stays and whether clients are receiving the services best suited to their needs. UR monitors services to determine that an agency's services are necessary and cost effective, and that resources are efficiently utilized.

10:37-9.4 Quality assurance (QA) plan

(a) The scope, organization, monitoring, evaluation and problem correction activities of the QA program shall be written and will be referred to as the QA plan.

(b) The QA plan shall describe an ongoing, systematic process of monitoring and evaluation of important aspects of care with participation by all levels of staff.

(c) The QA plan shall include or cross reference a description of indicators monitored in each program element. Indicators shall

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cover limited areas that are deemed to be high risk, high volume or problem prone.

(d) The QA plan shall include a description of outcome indicators monitored in each program element.

(e) The QA plan shall identify or cross reference thresholds for evaluation for each indicator.

(f) The QA plan shall include procedures for monitoring problem correction.

(g) The QA plan shall describe monitoring activities to ensure client involvement in treatment.

(h) The QA plan shall describe the scope of client participation in the QA program.

(i) The QA plan shall describe reviews of open and closed client records for timely completion of required documentation.

(j) The QA plan shall describe the process for reviews of open and closed client records to evaluate the quality and appropriateness of treatment.

(k) The QA plan shall specify the required sample size for review of open and closed client records. The rationale for sample size selected shall also be described in the plan.

(l) The QA plan shall describe the process, frequency, and criteria for selection of problem, high risk, difficult cases for Special Case Review. Special Case Reviews include, but are not limited to, incidents and adverse medication reactions.

(m) The QA plan shall describe the organizational structure, including lines of authority and how the QA program fits into this structure.

(n) The QA plan shall describe the persons responsible for QA activities.

(o) The QA plan shall describe the extent of medical staff participation in the QA program.

(p) The QA plan shall describe the organization and composition of the committee responsible for QA oversight.

(q) The QA plan shall describe the required frequency of committee meetings in which QA oversight occurs.

(r) In the case of hospital-based PAs, the QA plan shall describe the process for integration with the hospital QA program.

(s) The QA plan shall describe how QA findings are effectively communicated to all relevant components of the organization.

(t) The QA plan shall describe how supervision is utilized to identify and resolve QA issues.

(u) The QA plan shall describe how relevant findings are shared with clients.

10:37-9.5 Quality assurance (QA) implementation

(a) The QA plan shall be implemented.

(b) Data shall be routinely collected from ongoing monitoring activities and periodically evaluated and analyzed, based on thresholds.

(c) Documented reports of all ongoing monitoring and evaluation activities shall be produced. When ongoing monitoring reveals that more intensive evaluation is required, documentation shall include evidence of further assessment, conclusions drawn, and actions taken to improve care and to resolve identified problems. Examples of possible actions that can be taken are: implementation of inservice training, personnel action, changes in policies and procedures, administrative actions.

(d) Status of previously identified problems (follow-up) shall be documented. Problems identified and corrective actions taken shall be monitored for a prescribed time frame.

(e) To the extent that the QA process identifies issues that require medical staff input, review and response to such referrals shall be documented. These referrals may include questionable admissions and continued stays.

(f) Documentation and evidence of QA monitoring activities to ensure client involvement in treatment shall be provided, and shall include, at a minimum: each client's active and informed participation in his or her treatment plan; medication education; and application of clients' rights and the client grievance procedure.

(g) Documentation of monitoring of effectiveness of the PA's mechanisms to respond to client complaints and suggestions shall be provided.

(h) In the case of hospital based PAs, documented evidence of integration with the hospital QA program shall be available.

(i) There shall be evidence that relevant QA findings are effectively communicated to all relevant components of the PA, including clients.

(j) When the PA has developed the QA program, the following additional elements should be implemented:

1. Participation by medical staff on the QA oversight committee;

2. Documentation of analysis of aggregate QA findings to identify and address patterns and trends related to client characteristics, treatment and service utilization;

3. Utilization of responses to client satisfaction surveys and recommendations from clients and family members; and

4. Documentation of the use of applicable QA findings in ongoing staff development, supervision and performance evaluation.

10:37-9.6 Administrative support

(a) The PA administration shall require and support the QA program.

(b) PA administration shall review and approve the QA plan, as part of an annual QA plan review.

(c) QA reports shall be made available to the PA administration, as described in the QA plan.

(d) The annual appraisal of the QA program shall be submitted to the PA administration.

(e) There shall be documentation of administrative review of QA findings.

(f) When the PA has developed the QA program, the PA administration should also document use of QA findings for management decision-making and program planning (for example, link with goals and objectives, and long range or annual plans).

10:37-9.7 Quality assurance (QA) oversight

(a) A committee composed of a representative sample of individuals from the PA's program elements shall perform the function of oversight of organization-wide QA activities.

(b) Appropriate oversight functions shall include:

1. Annual review and reappraisal of the QA plan;

2. Review of problems which cannot be resolved at a program element level, recommending actions to resolve these problems, and following up to ensure correction takes place. These problems may reflect trends, patterns of performance, or problems that affect more than one program element;

3. Review and approval of program element QA indicators; and

4. Review and approval of revisions of QA policies and procedures.

(c) Minutes shall be kept of committee meetings in which QA oversight occurs. Client names shall not appear in minutes or circulated reports.

10:37-9.8 Utilization review (UR)

(a) Each QA program shall include a utilization review (UR) component which shall be described in the QA plan.

(b) The UR component of the QA program shall include a system, which shall include timeframes for review and which shall monitor the appropriateness of:

1. Admission, for at least 10 percent of all new clients each month; and

2. Continued stay, for at least 10 percent of the clients served by the PA during the previous year, with a representative sample from each program element.

(c) Written criteria shall be developed for admission and continued stay in each program element. These criteria shall be utilized during the UR activities described in (b) above.

(d) A written description for the processing of cases deemed inappropriate admissions and continued stays shall be developed. Action for inappropriate cases (those which do not meet criteria or receive approval by the medical reviewer) shall be effected through termination, transfer to an appropriate program or implementation of interventions necessary to facilitate termination.

(e) Criteria shall be developed for each program element for assessing length of stay. Level of functioning, severity of illness, diagnosis or other professionally accepted categories upon which

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length of stay norms are based shall reflect the clinical needs of the clients served by the PA and the PA's treatment philosophy.

(f) Continued service for a client who exceeds the identified length of stay norm shall be justified in the client's clinical record.

(g) Monthly UR statistical summaries shall be maintained and shall include the number of admission and continued stay reviews completed, as well as dispositions (for example, approvals, transfers, terminations).

(h) There shall be a written policy describing how UR findings and records are maintained to assure client and staff confidentiality. Client numbers and clinician codes are one acceptable method that can be used.

(i) There shall be a written conflict of interest policy that excludes a clinician who is involved in treatment of a client from making the determination of that client's appropriateness for continued stay.

(j) When the PA has developed the QA program, the PA should additionally document UR activities that address efficient use of staff and resources.

10:37-9.9 Risk management (RM)

(a) Each QA program shall include a risk management (RM) component which shall be described in the QA plan.

(b) The RM component of the QA program shall include the following activities:

1. Monitoring of implementation of PA's policies and procedures regarding medication (for example: documentation that staff are aware of medications prescribed for clients, dosage, frequency, side effects, and adverse medication reactions, frequency of laboratory tests when necessary);

2. Monitoring life safety;

3. An incident review and reporting procedure that will allow for the analysis of client and staff incidents to identify patterns and trends or opportunities to improve client care and staff safety and to reduce agency liability risks. Incident review shall include interviews of clients and staff involved in each incident. The PA shall ensure that clients and staff who report incidents are not adversely affected; and

4. Development of an infection control policy and monitoring of the implementation of the policy.

(c) Risk management reports shall document all RM activities. Conclusions, recommendations, actions to reduce risk or resolve problems and follow up of corrective actions taken shall be included in these reports.

(d) When the PA has developed the QA program, the following should be considered for inclusion in RM activities:

1. Monitoring of compliance with PA policies regarding confidentiality and release of information;

2. Identifying categories of potential risk in clinical aspects of care to clients;

3. Review of case-specific instances of potential risk; and

4. Documentation and implementation of a RM plan that fully describes the scope of the RM program and its integration with other QA activities.

10:37-9.10 Annual appraisal

(a) An annual appraisal of the QA program shall be conducted by the PA and documented.

(b) The annual appraisal shall include review of adequacy of monitoring, evaluation and reporting mechanisms, and evidence of solutions to identified problems.

(c) When the PA has developed the QA program, evidence of positive impact on client care and client input should also be included in the appraisal process.

SUBCHAPTER 10. SITE REVIEW AND CERTIFICATION

10:37-10.1 Scope and purpose

(a) Site reviews shall be conducted at every provider agency (PA) as defined at N.J.A.C. 10:37-9.3.

(b) The site review is designed as a collaborative process to promote learning, resource building and program improvement, high quality services and the protection of consumers' rights.

(c) Results of site reviews, including improvement plans and actions, shall be a key factor in contract or funding renewal decisions made by the Division.

(d) Individual programs provided by the PA shall be certified upon completion of a site review, if the programs conform to applicable rules promulgated by the Division in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

10:37-10.2 Team composition

(a) Site reviews shall be conducted by a team tailored to the specific characteristics of the PA being surveyed.

(b) Every team shall be coordinated and led by staff of the Division.

(c) Site reviews of direct service programs shall, whenever possible, include representatives from consumer and family organizations, staff from similar agencies (peers) and county mental health administrators.

(d) Staff from the PA to be reviewed shall have the opportunity to provide input into planning for the site review and shall be an integral part of the onsite process.

10:37-10.3 Site review activities

(a) Team composition, the amount of time scheduled for each site review and the level of intensity of each site review may vary to reflect the characteristics of individual PAs and the populations served.

(b) Site reviews may include, but not be limited to, consumer, direct care and administrative staff interviews, reviews of each program element, record reviews, reviews of policies and procedures, program observations, onsite inspection of the physical plant, review of internal PA documents, including financial records, and review of the quality assurance program.

(c) The review of each of these items shall be based on applicable State rules.

(d) The team shall present preliminary findings the last day of the site review at a summation meeting at the PA.

(e) At the conclusion of each site review, each PA shall be afforded the opportunity to provide feedback to the Division about the performance of the survey team, using a structured process, as determined by the Division.

10:37-10.4 Site review report

(a) An official report of findings and a determination regarding approval for certification shall be issued after review and approval of the Division's Assistant Director responsible for the contract or funding pertaining to the program(s) reviewed and of the Assistant Director for the Office of Quality Improvement and Specialty Services.

(b) Agencies shall be required to send a written response to the official report, including a plan for improvement, with timeframes specified within the official report.

(c) This response shall be attached to the report and together shall constitute a public document.

(d) PAs shall be notified in writing whether the improvement plan, or portions thereof, are approved for implementation and whether there are any areas that need to be addressed further.

10:37-10.5 Initial certification for pre-existing contracted agencies and programs

All PAs which have contracts with, or are funded by, the Division prior to *[the effective date of these rules]* ***August 16, 1993*** shall be issued an Initial Certification for those programs so funded by the Division once it has been determined that the PA is in good standing with no major contract or program deficiencies. The initial certification so provided shall be for periods up to three years and shall remain in effect until the next scheduled site review, or the non-renewal, or termination of a contract or funding with the Division, whichever comes first.

10:37-10.6 Provisional certification for new contract agencies or programs

(a) A provisional certification may be issued by the Division to a PA which is entering a contract with, or requesting funding from,

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the Division for a new program service and which indicates in writing an intent to comply with all applicable standards.

(b) The Division shall visit the program and assess its ability for compliance with applicable program standards. The Assistant Director responsible for a Division contract or funding for program services shall make the determination for provisional certification and shall notify the applicant of the determination.

(c) The provisional certification shall be issued for a time period not to exceed six months. If, in the Division's judgment, the applicant does not fully meet applicable or contracted provisions at the end of six months, the provisional certification may be extended for an additional six months. The provisional certification shall be extended beyond a second six month period only upon receipt by the Division of a written request from the applicant for such an extension which provides the basis for the request, and only after Division approval of the written request, which shall be based upon a determination of what is in the best interest of the clients.

(d) If the new PA meets applicable standards, a certification shall be issued by the Division.

10:37-10.7 Certification renewal or revocation

(a) The certification shall be for periods up to three years and may be renewed.

(b) Determination of certification renewal shall be based on whether the program meets the rules applicable at the time of renewal.

(c) The Division's Assistant Director responsible for contracts or funding for programs being certified shall make the determination of renewal or revocation.

(d) In the event that a certification expires prior to the determination of renewal, the certification shall remain in effect until such a determination is made.

(e) In the event that a determination is made not to renew certification or to revoke certification, the applicable Assistant Director will notify the PA.

(f) Revocation of certification may occur if it is determined by the Division that a PA is not in compliance with its contract or with applicable rules, in the event that the contract or funding for services is terminated or not renewed or if the life or safety of clients is endangered.

(g) If the PA does not submit the specified written response to a site review report by the required date or if violations have not been corrected within time frames specified in the approved PA response, the Division may revoke the current certification, not renew the certification of the PA or may elect other appropriate administrative actions.

(h) In the event that the Division revokes or does not renew the certification, the responsible Assistant Director shall send written notice to the PA's executive director or designee and to the PA's president of the board of directors providing the basis for the revocation or non-renewal.

10:37-10.8 Review of administrative determinations

Whenever certification is denied, revoked or not renewed and the PA disputes the basis of the action, the PA may apply to the Division Director for a review. A final agency decision shall be rendered within 30 days of the receipt of the written request for a review.

10:37-10.9 Administrative hearing of appeal

If the PA chooses to appeal a final agency decision made pursuant to these rules, the PA may request an administrative hearing, which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1, and the Uniform Administrative Procedure Rules, at N.J.A.C. 1:1.

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## (a)

## DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

### Medicaid Only
### New Eligibility Computation Amounts
### Adopted Amendments: N.J.A.C. 10:71-4.8, 5.4, 5.5, 5.6 and 5.9

Proposed: May 3, 1993 at 25 N.J.R. 1818(a).

Adopted: July 15, 1993 by William J. Waldman, Commissioner, Department of Human Services.

Filed: July 19, 1993 as R.1993 d.402, **without change.**

Authority: N.J.S.A. 30:4D-3; 30:4D-7, 7a, b and c; 42 CFR 435.210 and 435.1005; 20 CFR 416.1163 and 416.2025.

Effective Date: August 16, 1993.

Expiration Date: December 24, 1995.

**Summary** of Public Comments and Agency Responses: **No comments received.**

**Full text** of the adoption follows:

10:71-4.8 Institutional eligibility; resources of a couple

(a) In the determination of resource eligibility for an individual requiring long term care, the county welfare agency shall establish the combined countable resources of a couple as of the first period of continuous institutionalization beginning on or after September 30, 1989. This determination shall be made upon a request for a resource assessment in accordance with N.J.A.C. 10:71-4.9 or at the time of application for Medicaid benefits. The total countable resources of the couple shall include all resources owned by either member of the couple individually or together. The CWA shall establish a share of the resources to be attributed to the community spouse in accordance with this section. (No community spouse's share of resources may be established if the institutionalized individual's current continuous period of institutionalization began at any time before September 30, 1989.)

1. The community spouse's share of the couple's combined countable resources is based on the couple's countable resources as of the first moment of the first day of the month of the current period of institutionalization beginning on or after September 30, 1989 and shall not exceed $70,740 unless authorized in 4 or 5 below. The community spouse's share of the couple's resources shall be the greater of:

i. $14,148; or

ii. (No change.)

2.-9. (No change.)

10:71-5.4 Includable income

(a) Any income which is not specifically excluded under the provisions of N.J.A.C. 10:71-5.3 shall be includable in the determination of countable income. Such income shall include, but is not limited to, the following:

1.-11. (No change.)

12. Support and maintenance furnished in-kind (community cases): Support and maintenance encompasses the provision to an individual of his or her needs for food, clothing, and shelter at no cost or at a reduced value. Persons determined to be "living in the household of another" in accordance with N.J.A.C. 10:71-5.6 shall not be considered to be receiving in-kind support and maintenance as the income eligibility levels have been reduced in recognition of such receipt. Persons not determined to be "living in the household of another" who receive in-kind support and maintenance shall be considered to have income in the amount of:

$164.67 for an individual

$237.33 for a couple

i. (No change.)

13. (No change.)

(b) (No change.)

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10:71-5.5 Deeming of income
(a)-(f) (No change.)
(g) A table for deeming computation amounts follows:

TABLE A
Deeming Computation Amounts

1. Living allowance for each ineligible child $218.00

| 2. Remaining income amount | Head of Household | Receiving Support and Maintenance |
|---|---|---|
| | $ 218.00 | $ 145.33 |

3. Spouse to Spouse Deeming—Eligibility Levels

| | |
|---|---|
| a. Residential Health Care Facility | $1,149.36 |
| b. Eligibile individual living alone with ineligible spouse | $ 894.36 |
| c. Living alone or with others | $ 683.25 |
| d. Living in household of another | $ 527.76 |

4. Parental Allowance—Deeming to Child(ren)

| Remaining income is: | 1 Parent | Parent & Spouse of Parent |
|---|---|---|
| a. Earned only | $ 868.00 | $1,304.00 |
| b. Unearned only | $ 434.00 | $ 651.00 |
| c. Both earned and unearned | $ 434.00 | $ 651.00 |

10:71-5.6 Income eligibility standards
(a)-(b) (No change.)
(c) Non-institutional living arrangements:
1.-4. (No change.)
5. Table B follows:

TABLE B

| Variations in Living Arrangement | Medicaid Eligibility Income Standards | |
|---|---|---|
| | Individual | Couple |
| I. Residential Health Care Facility | $ 584.05 | $1,149.36 |
| II. Living Alone or with Others | $ 465.25 | $ 677.36 |
| III. Living alone with Ineligible Spouse | $ 677.36 | |
| IV. Living in Household of Another | $ 333.65 | $ 527.76 |
| V. Title XIX Approved Facility: Includes persons in acute general hospitals, nursing facilities, intermediate care facilities/mental retardation and licensed special hospitals (Class A, B, C) and Title XIX psychiatric hospitals (for persons under age 21 and age 65 and over) or a combination of such facilities for a full calendar month. | $1,302.00† | |

†Gross income (that is, income prior to any income exclusions) is applied to this Medicaid "cap".

(d) (No change.)

10:71-5.9 Deeming from sponsor to alien
(a)-(d) (No change.)
(e) To determine the amount of income to be deemed to an alien, the CWA shall proceed as follows:
1. (No change.)
2. Subtract $434.00 for the sponsor, $651.00 for the sponsor if living with his or her spouse, $866.00 for the sponsor if his or her spouse is a co-sponsor.
3. Subtract $217.00 for any other dependent of the sponsor who is or could be claimed for Federal Income Tax purposes.
4. (No change.)
(f) (No change.)

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# (a)

## DIVISION OF YOUTH AND FAMILY SERVICES

### Manual of Requirements for Residential Child Care Facilities

### Adopted New Rules: N.J.A.C. 10:127

Proposed: April 19, 1993 at 25 N.J.R. 1716(a).
Adopted: July 16, 1993 by William Waldman, Commissioner, Department of Human Services.
Filed: July 19, 1993 as R.1993 d.403, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:1-14 and 30:4C-4.

Effective Date: August 16, 1993.
Expiration Date: August 16, 1998.

**Summary** of Public Comments and Agency Responses:
The Division received comments from 23 sources. Of these, 16 commenters addressed specifically the use of tobacco products in residential child care facilities. The Division has responded to these comments collectively, since they all took the same position on the issue and supported and referenced the detailed comments submitted by one of the commenters. The Division has responded to the remaining commenters individually, as each commenter addressed different issues. A list of commenters follows:
Commenters addressing the use of tobacco in residential child care facilities:
1. John Slade, M.D., Associate Professor, Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey, New Brunswick, NJ.
2. Abby L. Hoffman, Project Coordinator, UMDNJ Project Addressing Tobacco in the Treatment of Other Addictions, New Brunswick, NJ.
3. Jacqueline Schreiber, M.S.W., Program and Policy Consultant, UMDNJ Project Addressing Tobacco in the Treatment of Other Addictions, New Brunswick, NJ.
4. Kit Riley, Ph.D. (no city or affiliation given).
5. Bruce Siegel, M.D., M.P.H., Commissioner, New Jersey Department of Health, Trenton, NJ.
6. Terrence O'Connor, Assistant Commissioner, New Jersey Department of Health, Trenton, NJ.
7. Nancy L. Fiorentino, M.S.W., Office of Policy and Research, New Jersey Department of Health, Trenton, NJ.
8. Norman Hymowitz, Ph.D., Chairman, Commission on Smoking or Health, New Jersey Department of Health, Trenton, NJ.
9. Neil E. Weisfeld, Director, Education, Research and Regulatory Affairs, Medical Society of New Jersey.
10. Pam Stewart, Warren County Council on Alcoholism and Drug Abuse, Belvidere, NJ.
11. Regina Carlson, Executive Director, New Jersey Group Against Smoking Pollution, Summit, NJ.
12. A.W. Comerford, M.A., C.A.C., Director of Outpatient Services, New Hope Foundation, Freehold, NJ.
13. Karen A. Spinner, Director, Public Education and Policy, New Jersey Association on Corrections, Trenton, NJ.
14. Marilyn Aguirre-Molina, Ed.D., President, Latino Council on Alcohol and Tobacco, Piscataway, NJ.
15. Geraldine O. Delaney, C.E.O. Emeritus and Founder, Little Hill Foundation, Blairstown, NJ

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16. William C. VanOst, M.D., F.A.A.P., The VanOst Institute for Family Living, Inc., Englewood, NJ.

Commenters addressing issues other than the use of tobacco:

17. Phyllis Yester, VisionQuest, Exton, PA.

18. Edward T. Brown, Bonnie Brae, Millington, NJ.

19. Jean Paashaus, Summit, NJ.

20. Susan G. Roth, Ed.D., Bonnie Brae, Millington, NJ.

21. Joseph K. Suozzo, New Jersey Department of the Public Advocate, Trenton, NJ.

22. Julie Turner, New Jersey Association of Children's Residential Facilities, Ridgewood, NJ.

23. Kenneth Tenley, Mapleton Center, Devereux Foundation, Malvern, PA.

COMMENT: John Slade, M.D., Director of the University of Medicine and Dentistry of New Jersey's Project on Addressing Tobacco in the Treatment of Other Addictions, commented on the proposed regulations regarding the use of tobacco in residential child care facilities. Comments were received from 15 other sources in support of Dr. Slade's views. The Division arranged for Dr. Slade and his staff to attend the June 11, 1993 meeting of a special Ad Hoc Committee, consisting primarily of residential facility providers and staff, which has assisted the Division in formulating the proposed new rules. The meeting provided an opportunity for an informative exchange of ideas, issues and concerns in this area and resulted in the development of additional rules that require residential child care facilities to prohibit smoking in buildings used by children and in vehicles when children are present.

Specifically, Dr. Slade objected to the proposed new rules providing that facilities may permit smoking or the use of smokeless tobacco by children, staff members or visitors, but only in a designated room or area of the facility. Dr. Slade was concerned that this practice would create a pollution problem because physical separation and a separate ventilation system for the designated room or area would not be required. He also indicated that permitting tobacco use by staff members would undermine a facility's efforts to discourage tobacco use by adolescents. He further urged that facilities be required to prohibit the possession or use of tobacco products by children in residence at the facility.

RESPONSE: The Division agrees in principle with this comment and has made additional changes at N.J.A.C. 10:127-4.6 that strengthen these rules and further restrict the use of tobacco products at these facilities, including a requirement that the facilities prohibit smoking in buildings or indoor areas used by children. However, the Division cannot agree at this time to a total ban on the possession or use of tobacco products at these facilities. The adolescents placed in these facilities have been unable to remain in community settings as a result of the severity of their emotional and acting-out behaviors. Since these are not addiction treatment facilities for the most part, the service and treatment programs have traditionally focused on remediating the residents' emotional disorders, rather than dealing with addiction-related behaviors. Prohibiting children from using or possessing tobacco, without providing an addiction treatment component, could exacerbate their emotional problems and impede the facility's ability to carry out their ongoing treatment plans.

COMMENT: Dr. Slade also suggested expanding the proposed amendments that require facilities to instruct children about the health consequences of tobacco, alcohol and drug use. He asked that the rules require a comprehensive prevention program that challenges the norms of the adolescent culture, which encourage use of these substances.

RESPONSE: The Division agrees with the intent of this comment, and has made changes at N.J.A.C. 10:126-4.6, 7.6 and 10.23 to include the potential social consequences in the required instruction about tobacco, alcohol and drug use. This will ensure that instruction goes beyond health consequences alone, without requiring a more comprehensive prevention program that would be economically prohibitive for many facilities to establish.

COMMENT: Dr. Slade also recommended adding new rules designed to require residential facilities to become tobacco-free within a specified transition period, such as three years. Staff who are addicted to nicotine should be required to undergo treatment, and newly hired staff should be free of nicotine addiction for six months prior to hiring. During the transition period suggested by Dr. Slade, facilities that permit tobacco use should be required to provide warning statements to parents and staff, obtain parental consent and physician's approval for a child's tobacco use, and require that designated smoking areas meet the Department of Community Affairs' definition and ventilation standards.

RESPONSE: The Division supports a long-range objective to strengthen these regulations over time, with the aim of ultimately achieving smoke-free environments in these residential facilities. The Division plans to evaluate the facilities' compliance with the adopted new rules and their progress in working towards the goal of establishing smoke-free environments. Before the newly adopted rules expire in five years, the Division plans to explore ways to strengthen the regulation further as needed. In the meantime, facilities may choose on their own volition to prohibit smoking or tobacco use on the entire campus, beyond the requirements of these regulations.

COMMENT: Dr. Slade also urged that smoking be prohibited in all vehicles operated by the facility, and that staff training in facilities for pregnant and parenting adolescents include training in tobacco abuse prevention.

RESPONSE: The Division agrees with these comments and has made the necessary changes. Amendments have been added at N.J.A.C. 10:127-8.1 to prohibit smoking in all vehicles when children are present, and at N.J.A.C. 10:127-10.3 to require staff in facilities for pregnant and parenting adolescents to receive training in drug, alcohol and tobacco abuse.

COMMENT: Phyllis Yester, Regional Quality of Care Director for VisionQuest of Exton, Pennsylvania, noted that due to the nature of VisionQuest's programs and in particular the mobile programs wagon trains, Quests, and OceanQuest, the youth in VisionQuest are provided religious activities and service at the program site, as opposed to transporting the youth to the community. Ms. Yester asked that the rules require that religious activities and services be provided, without specifying that youth will be transported to these services.

RESPONSE: The Division agrees with Ms. Yester's request and has made the necessary changes at N.J.A.C. 10:127-6.9(c) to reflect that youth may be provided religious activities and services at the site or provided with transportation to religious activities and services in the community.

COMMENT: Ms. Yester requested a change in the requirement for staff to wear protective head gear when horseback riding. VisionQuest requires all youth to wear protective head gear while horseback riding, but some staff who are experienced riders or wranglers sign a release of liability in lieu of wearing protective head gear.

RESPONSE: The Division agrees with this comment and has made the necessary changes at N.J.A.C. 10:127-9.8, to ensure that all youth continue to wear protective head gear, while allowing staff to decide for themselves whether or not they need to wear head gear while horseback riding.

COMMENT: Edward T. Brown, Acting Director for Residential Services for Bonnie Brae of Millington, New Jersey recommended that a planned biking trip be defined as one that is more than 10 miles in duration, rather than five miles in duration.

RESPONSE: The Division agrees with this comment and has made the necessary change at N.J.A.C. 10:127-9.4, now defining a planned biking trip as one that is more than 10 miles in duration.

COMMENT: Mr. Brown suggested that the requirement for two adults to accompany two children on biking trips is too strict. He indicated that one adult can safely control a group of two children while on a biking trip, and that the presence of two staff members is not necessary until there are three children on the trip.

RESPONSE: The Division agrees with this comment and has revised the requirement for two staff members to be present during a biking trip when the threshold number reaches four children in the group, with one staff member in the lead and one staff member following the group. The Division has made the necessary change at N.J.A.C. 10:127-9.4(c)5.

COMMENT: Mr. Brown has recommended changing the wording for the required system for measuring a rope's usable life, for use in activities known as "ropes initiatives."

RESPONSE: The Division agrees with this comment and has amended the wording at N.J.A.C. 10:127-9.9 to reflect a clearer statement of the system for measuring the amount of time that ropes may safely be used for rope initiatives adventure activities.

COMMENT: Mr. Brown has recommended adding survival equipment as defined by the Federal Boat Safety Act of 1971 to the equipment required for boating activities.

RESPONSE: The Division agrees with this comment and has expanded the boating requirements at N.J.A.C. 10:127-9.10(b)3 to include specific survival equipment as delineated by the Federal Boat Safety Act of 1971. The equipment includes personal flotation devices, fire extinguishers, a bailing device, radiotelephone or signaling device, water-

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proof flashlights, anchor and line, tool kit, emergency food and drinking water, navigation equipment and charts, ground tackle, oars/paddles, and an appropriate size first aid kit.

COMMENT: Mr. Brown recommended adding a weather conditions check and the phone number of the local National Park Service to the information required to be on file prior to each boating activity.

RESPONSE: The Division agrees with this comment and has made the necessary changes at N.J.A.C. 10:127-9.10(b)4 and 5 to include a weather conditions check and the phone number of the local National Park Service in the requirements for developing a plan for each boating activity.

COMMENT: Mr. Brown recommended clarifying the wording on the different classes of boats used in boating activities.

RESPONSE: The Division agrees with this comment and has reworded the classification of boats at N.J.A.C. 10:127-9.10(d) to read: Class A—boats less than 16 feet; Class 1—boats 16 feet and over but less than 26 feet; Class 2—boats 26 feet and over but less than 40 feet; and Class 3—boats 40 feet and over.

COMMENT: Mr. Brown recommended increasing the distance between latrines and campsites or bodies of water from 100 feet to 200 feet, when children are taken on camping trips.

RESPONSE: The Division agrees with this comment and has made the necessary changes at N.J.A.C. 10:127-9.15(j)3, to reflect currently accepted practices for camping and the placement of latrines.

COMMENT: Mr. Brown recommended removing redundant wording that required a written policy on the treatment for ingestion of poisonous plants.

RESPONSE: The Division agrees with this comment and has made the necessary change at N.J.A.C. 10:127-9.17(c)2.

COMMENT: Jean Paashaus of Summit, New Jersey requested that new sections of the manual of requirements appear in boldface type to distinguish them from existing requirements.

RESPONSE: The Division disagrees with Ms. Paashaus's comment because when proposing new rules or changes to existing rules, the Division is mandated to comply with all of the Office of Administrative Law's Rules for Agency Rulemaking, pursuant to N.J.A.C. 1:30, and the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), which are the established procedures for publishing a proposal in the New Jersey Register. Boldface type was not used because the changes to the manual of requirements were of such magnitude that they necessitated a proposed repeal of the existing Manual of Requirements for Residential Child Care Facilities, which may be found in the New Jersey Administrative Code at N.J.A.C. 10:127, and proposed new rules, the full text of which appeared in the New Jersey Register at 25 N.J.R. 1716, April 19, 1993.

COMMENTS: Ms. Paashaus recommended that no high risk adventure activity be permitted in licensed facilities, and stated that adventure activities have been banned in some western states following deaths of participants, which she claims were cited in New Jersey legislation opposing the use of these activities. She commented that the proposal should not permit high risk activities such as caving, ropes initiatives, rock climbing and solo camping.

RESPONSE: The Division disagrees with this comment. Provisions of this manual of requirements that focus on adventure activities were developed by the Division as part of a Federally funded licensing grant project. As part of the licensing grant, the Division developed National Model Regulations that were widely disseminated in the residential services field, and were used as the basis for all of the proposed adventure activity requirements. These rules reflect extensive input and review from experts, licensors, and professionals across the country over a period of two years. Also, the Division included representatives from programs that provide these activities as part of an Ad Hoc Citizens Advisory Committee that helped the Division formulate the adventure activity requirements. The safety practices specified in the adventure activity regulations originate from a review of the literature, site visits and the recommended practices of some 24 national organizations involved in one or more adventure activities.

Evaluations of adventure programming have demonstrated that participants can apply what they discovered about themselves during adventure activities to other areas of their lives. Research has shown that traditional services are insufficient in helping youth achieve similar gains. These rules apply the principle of risk/benefit by specifying: (1) treatment planning and staffing requirements to increase the likelihood that youth can realize the benefits of adventure activities; (2) safety practices to reduce and minimize risk; and (3) procedures for informed consent, so the individual is aware of the risks and freely agrees to participate, including the consent of the parent or legal guardian to establish informed consent for minors. Facilities providing one or more of the 12 types of permitted activities must follow specific safety practices pertaining to that activity and ensure that staff are properly trained to conduct the adventure activity. In addition, all high and medium risk adventure activities must be approved by the Division's Bureau of Licensing prior to implementation by any licensed residential facility.

COMMENT: Ms. Paashaus urged that aversive conditioning not be used, even with the required approval of the Division's Bureau of Licensing, because of its negative effect on those staff using such techniques.

RESPONSE: The Division disagrees with this comment. The rule on aversive conditioning techniques applies only to children who are unable to respond to other methods of intervention, and not to the general population of children served. The use of such techniques is permitted only with developmentally disabled children, and only with prior approval by the Bureau of Licensing. If there are concerns about a particular aversive conditioning technique prior to approving its implementation at a residential facility, the Bureau will seek the advice and expertise of the appropriate medical expert(s) before making an informed decision.

COMMENT: Susan G. Roth, Ed.D., Executive Director of Bonnie Brae in Millington, New Jersey, commented on the requirements for community participation in the facility's administration. She suggested amending this section to reflect standard practice, including a governing board responsible for establishing and assuring the facility's mission, planning, and policies for finances, personnel, development, and public relations. The governing board should also be responsible for the facility's compliance with laws and standards.

RESPONSE: The Division agrees with this comment and has made the necessary change at N.J.A.C. 10:127-3.4 to reflect standard practice for governing boards.

COMMENT: Dr. Roth commented that the Division should add the phrase "or guardians" wherever the word "parents" appears throughout the manual of requirements.

RESPONSE: The manual states at N.J.A.C. 10:127-1.3 that a "parent" means a birth or adoptive parent, legal guardian or any other person having responsibility for, or custody of, a child. Therefore, the suggested addition is not necessary.

COMMENT: Dr. Roth suggested clarification of the requirement for naming the staff member "responsible for implementation of each treatment goal and objective." She recommended that this requirement refer to the "implementation of interventions or techniques to meet each treatment goal and objective." This wording would allow for several staff members to be involved in helping a child meet goals and objectives.

RESPONSE: The Division agrees with this comment and has made the necessary change at N.J.A.C. 10:127-6.1(e)8 to include the recommended wording.

COMMENT: Dr. Roth recommended adding a statement to the requirements for visitation policy, indicating that the child may contact his or her Division case manager, in addition to receiving visits from the case manager.

RESPONSE: The Division agrees that children should be permitted to contact their case managers; however, this provision is already included at N.J.A.C. 10:127-6.6(c)1.

COMMENT: Dr. Roth opposed the rule requiring the facility to send a letter to a child's parents and the Division's case manager informing them of the frequency and duration of any restrictive behavior management practice that was used with the child, and how the child responded to the restrictive behavior management practice. She indicated that reports should compare the effectiveness of the restrictive behavior management practice to other interventions, describe the child's behavior prior to the use of the restrictive practice, and compare the frequency and duration of such practices to their frequency and duration in previous time periods. She expressed concern that it is never acceptable clinical practice to report raw data to clients, parents, staff, or others as it leaves too much room for misinterpretation. Kenneth Tenley, Executive Director of the Mapleton Center of the Devereux Foundation, also objected to the requirement for the facility to report the use of a restrictive behavior management practice to parents.

RESPONSE: The Division disagrees with this comment. The requirement to report the use of restrictive behavior management practices to the child's parents and the Division's case manager is a minimum reporting requirement. The requirement does not preclude the facility from reporting the additional information Dr. Roth mentioned. In ad-

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dition, further information about the child is provided to the child's parents and Division case manager at the treatment planning meeting. If they do not attend the meeting, the facility must send them a written summary of the meeting and a copy of the child's treatment plan to keep them informed of the child's progress and treatment status.

COMMENT: Dr. Roth recommended changing the requirement for written informed consent from the child's parents before administering psychotropic medication, to allow the facility to obtain general consent to provide medical treatment, including the use of psychotropic medication, as needed, with the facility sending the parents a letter if medication has been prescribed. She suggested that parental consent for psychotropic medication is a responsibility that is beyond parents' expertise, and that the requirement denies children the opportunity for timely professional treatment.

RESPONSE: The Division disagrees with this comment. Pursuant to New Jersey Department of Human Services Administrative Order 2:17, The Administration of Psychotropic Medication to Minors in Institutions and Similar Settings, facilities regulated by the Division are required to seek parental consent prior to the administration of psychotropic medication to a child. In keeping with this administrative order, the manual specifies that psychotropic medication may be administered to a child only if informed consent has been received from the parents and from all children 14 years of age and older, consistent with their age and level of functioning, unless the facility documents that the child lacks the capacity for informed consent. This consent is in addition to any general consent for treatment which the parent may also have signed. Further provisions in the manual permit the facility to waive the requirement for informed consent for psychotropic medication, if the treating physician certifies in the child's clinical record that an emergency exists. These regulations help ensure that children receive timely professional treatment and at the same time ensure the health, safety and welfare of children receiving psychotropic medication.

COMMENT: Dr. Roth objected to the requirement that facilities give parents the opportunity for consultation with a physician regarding proposed psychotropic medication for their child. She stated that neither the parents, the facility nor the Division can afford to pay for parents to have lengthy consultations with a pediatrician or psychiatrist. These professionals do have such meetings with agency staff who then consult with parents.

RESPONSE: The Division disagrees with this comment. In order to ensure proper informed consent, the physician should be made available for consultation to the child or parent to respond to any concerns about the medication, and to explain the child's condition, the reasons for prescribing the medication, the benefits and risks of taking the medication, and the advantages and disadvantages of alternative courses of action.

COMMENT: Joseph F. Suozzo, Assistant Director of Litigation, New Jersey Department of the Public Advocate, commented that a facility's violations of children's rights or visitation and communication problems should be specified as grounds that would warrant withholding of a temporary certificate or approval, or action against a facility's regular certificate of approval.

RESPONSE: The Division agrees that violations of children's rights or visitation and communication problems are serious violations of the manual. However, it is not necessary to list specific grounds for withholding or removing a facility's certificate, as this is determined on a case-by-case basis. The Division's Bureau of Licensing reviews the facility's compliance with the rules on children's rights, visitation and communication, as well as all other applicable requirements, before issuing or taking enforcement action on a certificate.

COMMENT: Mr. Suozzo commented on the provision specifying that the Bureau of Licensing may permit a facility that has requested an administrative hearing to continue to operate until a final decision is rendered. This rule fails to provide an adequate standard against which the Bureau's exercise of discretionary authority to permit continued operation of a facility pending an administrative hearing can be judged. A more definite standard should be adopted, such as establishing a rebuttable presumption of either permitting or denying continued operation.

RESPONSE: The Division disagrees with this comment. A general standard would be inappropriate, as each situation is evaluated on a case-by-case basis. In some cases a court will have to make the final decision on a facility's continued operation. When the Division determines that children are not at risk and that no imminent dangers exist, the Bureau of Licensing reviews the case and may permit a facility that has requested an administrative hearing to continue to operate, depending on the nature of the violations that were cited.

COMMENT: Mr. Suozzo commented that a precise time limit should be specified for the Division to investigate complaints against a facility. The rule specifying that complaints must be promptly investigated should be changed to require investigation within five days.

RESPONSE: The Division disagrees with this comment. The Bureau needs the discretion to determine when a complaint will be investigated based on the nature of the complaint. In some instances there are serious allegations that are investigated immediately, while minor concerns may be given lower priority and investigated after five days have elapsed.

COMMENT: Mr. Suozzo commented that the proposed response time of 48 hours for investigating complaints alleging an imminent hazard or risk to the health, safety and welfare of the children is too long. The response time for investigating such complaints should be 24 hours. Kenneth Tenley also recommended a 24-hour response time for such complaints.

RESPONSE: The Division disagrees with this comment and has made the necessary change at N.J.A.C. 10:127-2.5(b), requiring the Bureau to investigate such complaints within 24 hours.

COMMENT: Mr. Suozzo commented that the manual should explicitly refer to the statutory rights accorded children in residential placement by the Child Placement Bill of Rights Act, N.J.S.A. 9:6B-1 et seq. The Division should design and require facilities to post a standard statement of children's rights, allowing for additions (but not for deletions) to reflect any additional rights accorded by the facility. Kenneth Tenley also recommended that the Division develop a standard statement of children's rights.

RESPONSE: The Division fully realizes the importance of including children's rights in the manual of requirements. The proposal has been amended at N.J.A.C. 10:127-3.2 to include a reference to the Child Placement Bill of Rights Act.

The Division disagrees with the comment that a statement of children's rights must be posted in the facility. While children should be made aware of their rights, other methods of notification are equally effective in some settings. Different methods apply depending on the treatment modalities being used, the type of facility, and the nature of the population being served.

The Division disagrees with the comment that it should develop and promulgate a standard statement of children's rights. The manual already specifies at N.J.A.C. 10:127-3.2 the minimum information to be included in the list of children's rights to be developed by the facility. The Bureau of Licensing reviews each facility's statement to ensure that all the specified information is included without deletions.

COMMENT: Mr. Suozzo commented that the rules requiring children to have unimpeded access to the Division should also require unimpeded access to children's attorneys and to the Division's child abuse "hotline." The rules on telephone access by children appear to undermine these guarantees by requiring access only to the child's case manager or other professionals involved in the child's treatment planning.

RESPONSE: The Division agrees with this comment and has amended the proposal at N.J.A.C. 10:127-3.2(a)6 and 10:127-6.6 to require access to other professionals, as well as those involved in treatment planning.

COMMENT: Mr. Suozzo recommended that facilities be required to provide all parents with a copy of the facility's written behavior management policy, including an explanation of any restrictive behavior management practices used, instead of providing the copy on request only. He also recommended that the rights of parents and children should be combined into a single section of the manual for easier reference.

RESPONSE: The Division agrees that facilities should be required to provide all parents with a copy of the facility's written behavior management policy, and has made the necessary change at N.J.A.C. 10:127-3.3(a)8. The Division disagrees with the recommendation to combine rights of parents and children into a single section. The proposed rules are organized so that parents' and children's rights are addressed in the context of the relevant topic and subchapter, making it easier for facilities to plan procedures for each program component.

COMMENT: Mr. Suozzo recommended that the manual should provide for the appropriate release and inspection of children's records by agencies other than the Division, such as the State Protection and Advocacy Program. Policies on the release of children's records should not be subject to uneven case-by-case development at each facility.

RESPONSE: The Division agrees with this comment and has amended the proposal at N.J.A.C. 10:127-3.8(a) to require facilities to comply with

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all applicable laws and regulations governing the release of children's records.

COMMENT: Mr. Suozzo commented that the rules do not provide adequately for the child's participation in the treatment plan, in contravention of N.J.S.A. 9:6B-4i and 1, and that the child's parents are included in the treatment team only if appropriate. The treatment team should include parents or guardians, unless there is an explicit legal basis to exclude them. He also objected to the provisions for a facility to document why a treatment plan is not explained to parents. Only extraordinary circumstances should allow a facility to exclude parents from fully participating in the treatment plan.

RESPONSE: The Division does not agree that the rules fail to comply with N.J.S.A. 9:6B-4 in the Child Placement Bill of Rights Act. This law requires children's participation in their placement plan, which is different from the treatment plan specified in the manual. While children's participation is an essential part of their placement plan, it is usually inappropriate for their treatment plan, since children cannot be expected to evaluate their own disorders.

The Division agrees that parents should be included in the treatment team except in extraordinary circumstances. The manual has been changed at N.J.A.C. 10:127-6.1(b)6 to require the treatment team to include the child's parent(s) or legal guardian unless there is an explicit legal or medical basis to exclude them. The Division also agrees that the treatment plan should be explained to the child and the parents, with rare exceptions. The manual requires the facility at N.J.A.C. 10:127-6.1(c) to document in the child's record that the parents were invited to participate as members of the treatment team and assist in the development of the treatment plan and all subsequent revisions. It further requires the facility at N.J.A.C. 10:127-6.1(g) to ensure that the child's treatment plan and any revisions to it are explained to the child and his or her parents. However, the Division recognizes that some parents fail to attend the treatment plan meeting, and do not respond to other attempts to contact them, even after the Division and the facility have done everything possible to encourage the parents' participation. To ensure that there is adequate justification for excluding parents in these instances, the facility is required at N.J.A.C. 10:127-6.1(g) to document the reasons why the plan was not explained to the parents.

COMMENT: Mr. Suozzo commented that the provisions for discharge planning inadequately reflect the role of Case Assessment Resource Teams (CARTs) in residential placements. The rules should explicitly require the facility to contact the CART coordinator in the county to which the child is returning, and to coordinate discharge plans with the child, the family, the placing agency and the service providers who will be assisting the child after discharge.

RESPONSE: The Division agrees that discharge planning should be a coordinated effort among the child, the family, the placing agency, the service providers, the CART coordinator and the Division's district office caseworker and case placement team. However, there is no need to amend the manual, as it already requires the facility at N.J.A.C. 10:127-6.1(e)12 to include discharge planning in the child's treatment plan, which is developed by the treatment team including the district office caseworker. Division district office staff are responsible for all coordination with CARTs and will initiate any necessary contact between the discharging facility and the CART coordinator. CARTs address case practice issues regarding a child's entrance to and exit from a residential placement. As such, they are beyond the scope of this manual, which regulates the physical plant and programming of the residential facility.

COMMENT: Mr. Suozzo commented that there is an implicit exclusion of parents and family permitted to visit the child, contravening N.J.S.A. 9:6b-4e and f, which provides for parental and sibling contact "on a regular basis," and assistance from the Division to facilitate that contact. Kenneth Tenley also objected to the treatment team's authority to determine which family members and friends may communicate and visit with the child.

RESPONSE: The Division disagrees with this comment. The manual provides for reasonable access for contact with parents and family members, and includes parents in the treatment team that determines the family members and friends with whom the child may communicate and visit. In some cases, visitation by certain family members may be harmful to the child and detrimental to the treatment plan.

COMMENT: Mr. Suozzo objected to the requirement that out-of-State facilities ensure that school age children receive the educational instruction to which they are entitled under that state's law. The manual should not substitute other states' educational standards for New Jersey requirements when children are placed in facilities outside New Jersey. Such substitution would contravene the State constitutional mandate for school children to receive a "thorough and efficient" education.

RESPONSE: The Division agrees that children placed in out-of-State facilities should receive the same standard of education as children in New Jersey. However, it is beyond the authority of the Division to determine whether the education provided under other states' laws meets the requirements of New Jersey's constitution. Before children are placed in facilities located in other states, the New Jersey Department of Education reviews the facility's provisions for children's education and evaluates the education laws and regulations of the state in which they are located. It is not necessary or appropriate for the manual to regulate this process.

COMMENT: Mr. Suozzo recommended that the provisions for enabling children to attend religious services should be amended to apply "unless deemed clinically inappropriate," rather than "when deemed clinically appropriate."

RESPONSE: The Division agrees with this comment and has made the necessary change at N.J.A.C. 10:127-6.9(c).

COMMENT: Mr. Suozzo recommended that the implementation of a mechanical restraint should require approval from both the facility's administrator and the staff physician or consulting physician, rather than from either source alone.

RESPONSE: The Division disagrees with this comment. The special Ad Hoc Citizen's Advisory Committee which helped develop these regulations, comprised of several residential facility directors, administrators and staff members, advised the Division that either the facility administrator or staff/consulting physician has the expertise and experience to approve the implementation of a mechanical restraint. Requiring two sources of approval could cause undue delay in situations where a child's behavior needs prompt intervention.

COMMENT: Mr. Suozzo objected to the provisions authorizing periodic unannounced searches of children's rooms and possessions, without cause or reasonable suspicion, when the facility has adopted such a policy in advance. Because such searches implicate important constitutional rights applicable to children, fourth amendment protections from unreasonable search and seizure are applicable.

RESPONSE: The Division agrees with this comment and has made the appropriate change at N.J.A.C. 10:127-6.15(e) to require a facility to have a reasonable suspicion before searching a child's room and other possessions for contraband, stolen property or weapons.

COMMENT: Mr. Suozzo objected to the provision for blood or urine screening for substance abuse when ordered by a physician who has determined that such testing is necessary. The rule is too vague and inadequate to support a medical order for involuntary drug screening.

RESPONSE: The Division agrees with this comment and has changed the manaul at N.J.A.C. 10:127-6.15(g)1iii to permit drug screening when ordered by a physician who has determined that such screening is necessary through review of the child's previous case history and current behavior.

COMMENT: Julie Turner, Executive Director of the New Jersey Association of Children's Residential Facilities, expressed concerns regarding any additional costs the revised regulations may impose on facilities. She asked the Division to explain what the additional costs are; what the proposed amendments contribute to children's care or safety; why it is necessary to increase the regulations substantially; and whether all the required records are essential.

RESPONSE: The Division has reviewed these comments and responds as follows: These proposed rules will clarify and expand the requirements for residential facilities. They will not place any unnecessary, excessive or overly stringent standards on the facilities. The proposed manual establishes minimum baseline reporting, recordkeeping and other requirements with which these facilities must comply in order to ensure a safe, healthy and therapeutic environment for the emotionally disturbed children served in these settings. These requirements are utilized by the Division as the main criteria for establishing the costs of services and for developing contracts. The Division does not anticipate any negative economic impact of the proposed rules, since most facilities are already providing these services. Facilities that choose to utilize adventure activities may incur some minor expenses for additional safety equipment and staff certifications. These requirements help to ensure the safety of children who are participating in an approved adventure activity.

COMMENT: Kenneth Tenley, Executive Director of the Mapleton Center of the Devereux Foundation, recommended that facilities be required to post their statement of purpose.

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RESPONSE: The Division disagrees with this comment. The statement of purpose is required to be made available to all staff members, and given to parents. Posting is not necessary and may be cumbersome, since some statements of purpose are quite lengthy.

COMMENT: Mr. Tenley objected to the requirement for the facility to give parents a document explaining procedures for complaints, review of the facility's policies and inspection/violation reports, and reporting child abuse or neglect. He recommended that this information be provided to parents by the Division, to avoid an adversarial relationship between the parents and the facility.

RESPONSE: The Division disagrees with this comment. It is the facility's responsibility to provide information concerning the facility's policies, inspection/violation reports, and other topics that are specific to each facility and may not be known by the Division. Making parents aware of procedures for complaints and reporting child abuse/neglect is an important consumer protection that may reassure parents that the facility is subject to Division oversight and inspection.

COMMENT: Mr. Tenley commented that the prohibition against "frightening treatment" should be deleted as the term is difficult to define.

RESPONSE: The Division disagrees with this comment. Frightening treatment should continue to be prohibited and should be reported as possible child abuse. The determination of whether a particular treatment is frightening will be made on a case-by-case basis by the Division.

COMMENT: Mr. Tenley commented that it is unnecessary and burdensome for the facility to give a copy of its conflict of interest policy to all staff.

RESPONSE: The Division disagrees with this comment. A copy of the facility's conflict of interest policy must be posted or kept on file at the facility, and must be given to all governing board members and staff members to ensure that they are aware of the necessary procedures to avoid such conflicts.

COMMENT: Mr. Tenley suggested that the Division's child abuse "hotline" be used to report unauthorized absences by children from the facility, including runaways.

RESPONSE: The Division disagrees with this comment because the Division's toll-free telephone "hotline" does not accept out-of-State calls. Instead, a separate telephone number for the Office of Child Abuse Control is specified for out-of-State facilities to report unauthorized absences including runaways.

COMMENT: Mr. Tenley recommended that fire drills be conducted on all three operating shifts, and that a maximum length of time be established to evacuate the facility in a fire drill.

RESPONSE: The Division agrees with this comment and has made the necessary changes at N.J.A.C. 10:127-4.5(c).

COMMENT: Mr. Tenley suggested the facility be required to develop the child's initial treatment plan within 14 days instead of within 30 days.

RESPONSE: The Division disagrees with this comment. Facilities may need more than 14 days to complete the treatment plan in some cases. A facility may choose to complete treatment plans in less than 30 days as a facility policy.

COMMENT: Mr. Tenley suggested that the objectives in the child's treatment plan should be measurable.

RESPONSE: The Division agrees with this comment and has made the necessary change at N.J.A.C. 10:127-6.1(e)7.

COMMENT: Mr. Tenley recommended that a physician's written order be required to document the physician's recommendation to extend the time a child may be excluded from the group as a behavior management intervention.

RESPONSE: The Division agrees with this comment and has made the necessary change at N.J.A.C. 10:127-6.13(j)6.

COMMENT: Mr. Tenley objected to the requirement for posting the facility's policy regarding search and seizure, as this is detrimental to facility culture and not therapeutic for the children.

RESPONSE: The Division disagrees with this comment. It is standard practice to post search and seizure policy in areas conspicuous to children, as a reminder to children especially those returning to the facility from a leave or trip. It is in the best interests of children to have this policy posted.

COMMENT: Mr. Tenley recommended that all staff members be required to submit a written statement of health from a licensed physician, not just those staff members who are in contact with children at least eight hours a week.

RESPONSE: The Division disagrees with this comment. Adding a requirement for a health statement from all staff members would be excessively burdensome on the facility and on part-time staff members. Staff who are in contact with children less than eight hours a week would be unlikely to pose any health risk to children. Such staff members may include maintenance and clerical employees, as well as substitute caregivers and student teachers who have limited contact with children.

COMMENT: Mr. Tenley recommended that staff members should have a medical examination within 60 days before employment, not six months as stated in the proposal.

RESPONSE: The Division disagrees with this comment. A medical examination no more than six months old is sufficient to verify an employee's health. Requiring a medical examination within 60 days would be too restrictive and would require a second examination for those staff members who had been examined within three to five months before employment.

COMMENT: Mr. Tenley recommended referring to helping a child with "overcoming" instead of "getting over" his or her fears of a particular adventure activity.

RESPONSE: The Division agrees and has made the necessary change at N.J.A.C. 10:127-9.1(i).

COMMENT: Mr. Tenley objected to the requirement for submitting a written description to the Bureau of Licensing before the facility implements medium-risk adventure activities, such as canoeing, boating, water skiing and snow skiing. Such reporting would be unnecessary and burdensome.

RESPONSE: The Division disagrees with this comment. A written description of these medium-risk activities is necessary to ensure that the proper safety procedures are followed and that qualified staff are supervising the children.

COMMENT: Mr. Tenley commented that the requirement for every canoe and kayak to have an extra paddle is not necessary. An extra paddle for every two or three canoes would be sufficient.

RESPONSE: The Division agrees with this comment and has made the necessary change at N.J.A.C. 10:127-9.5(f)2 requiring an extra paddle for every three canoes or kayaks on a canoeing or kayaking trip.

**Summary** of Agency-Initiated Changes:

There are several technical changes made in grammar, spelling and punctuation. There are also several minor substantive changes to the text initiated by the Division upon adoption. At N.J.A.C. 10:127-3.2(e), the facility is required to explain its grievance procedure to children who are unable to read or unable to hear. This will ensure that disabled or illiterate children will understand how to present a grievance. At N.J.A.C. 10:127-5.2(c)3, the qualifications for social workers are clarified pursuant to N.J.S.A. 45:15BB-1 et seq. (The Social Workers Licensing Act of 1991). This clarification is necessary to comply with State law. At N.J.A.C. 10:127-6.13(j)5, the facility is prohibited from using any unapproved area to exclude a child from the group as a restrictive behavior management practice. This requirement is designed to protect children from safety hazards in areas that have not been approved by the Bureau. At N.J.A.C. 10:127-6.14(a)4, an incorrect citation regarding house rules has been deleted, as there is no mention of house rules in the cited section (N.J.A.C. 10:127-3.3). At N.J.A.C. 10:127-7.6(b)3, shampoo is included as a hygiene supply to be provided. At N.J.A.C. 10:127-7.6(e) and 10.23(c), the facility is required to provide adequate footwear for children, in order to ensure their health, safety and comfort. At N.J.A.C. 10:127-7.7(b), the one-year time limit for Mantoux tuberculin skin tests completed by staff before hiring has been deleted, based on the Division's consultation with the Department of Health. A negative Mantoux test is a reliable indicator of the absence of tuberculosis, and indicates little likelihood of contracting it in the future. At N.J.A.C. 10:127-9.1(k), the facility is prohibited from offering bungee jumping as an adventure activity. The serious risks of bungee jumping far outweigh any benefits of this activity, and the Citizens Advisory Committee supports this prohibition. At N.J.A.C. 10:127-10.1(b)5, facilities that serve pregnant and parenting adolescents are required to provide prenatal and postnatal care for the adolescents. Such care is essential for the health of adolescent mothers. At N.J.A.C. 10:127-10.8, the facility's parenting education program is required to include infant safety issues, to ensure that adolescent mothers provide for their infants' safety. At N.J.A.C. 10:127-10.21, a citation is corrected to indicate that the facility is prohibited from using a self-made bleach solution to disinfect children's bed linens. Commercially prepared disinfectant is a safer and more consistent product to be used for this purpose.

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

CHAPTER 127
MANUAL OF REQUIREMENTS FOR RESIDENTIAL CHILD CARE FACILITIES

SUBCHAPTER 1. GENERAL PROVISIONS

10:127-1.1 Legal authority

(a) This chapter is promulgated pursuant to N.J.S.A. 30:1-14 and 15 and 30:4C-4.

(b) Under N.J.S.A. 30:1-14 and 30:4C-4, the Department of Human Services is authorized to inspect, evaluate, and approve publicly or privately operated facilities that provide board, lodging, care and treatment services for children who are placed and/or financed by the Division of Youth and Family Services or any other New Jersey State agency.

(c) Under N.J.S.A. 30:1-14, the following facilities shall be subject to inspection, evaluation, and approval by the Department of Human Services, Division of Youth and Family Services:

1. New Jersey-based children's residential facilities, as defined in this chapter, except facilities that are licensed, approved or regulated pursuant to State law by the Division of Developmental Disabilities or the Division of Mental Health and Hospitals, both of the Department of Human Services, by the State Department of Health, by the State Department of Education, by the State Department of Corrections or by any other New Jersey State agency; and

2. Out-of-State children's residential facilities as defined in this chapter, that serve one or more children under the supervision of the Division of Youth and Family Services. As a condition of approval by the Department, such facilities shall be licensed, certified, or otherwise approved to operate in the state where the facility is located.

(d) In order to be approved, a children's residential facility shall demonstrate to the satisfaction of the Department of Human Services or its duly authorized agent that it complies with all applicable provisions of this chapter.

(e) Responsibility for ensuring that the facility specified in (c) above complies with the provisions of the statutes cited in (a) above and of this chapter is delegated by the Department of Human Services to the Division of Youth and Family Services, Bureau of Licensing. The Division is authorized to visit and inspect such facilities, as described in N.J.A.C. 10:127-1.2(a) and (b), to determine the extent of their compliance with such provisions.

(f) Under N.J.S.A. 30:1-15, the Department of Human Services is also authorized to visit and inspect publicly or privately maintained institutions or other institutions and noninstitutional agencies that:

1. Provide board, lodging or care for children who are not placed or financed by the Division of Youth and Family Services or any other New Jersey State agency; and

2. Are not subject to licensing or regulation by any New Jersey State agency.

(g) The Division of Youth and Family Services is authorized to visit and inspect such facilities as described in (f) above to assess the general health, safety, and well-being of the children and the care and treatment they are receiving, but cannot require their compliance with this chapter and must secure an order from a court of competent jurisdiction, pursuant to N.J.S.A. 30:1-16, to compel correction of serious deficiencies.

10:127-1.2 Definition and types of children's residential facilities

(a) "Residential child care facility" or "residential facility" or "facility" means any public or private establishment that provides room, board, care and treatment services for 16 or more children on a 24 hour-a-day basis.

(b) Residential child care facilities that are subject to the provisions of this chapter include:

1. Division-contracted or Division-operated residential child care facilities that serve children with emotional and/or behavioral problems and provide on-grounds educational programming;

2. Division-contracted or Division-operated residential child care facilities that serve children with emotional and/or behavioral problems who attend schools in the community; and

3. Division-contracted residential child care facilities that provide:

i. Drug and alcohol treatment services;

ii. Psychiatric services;

iii. Services to children with physical disabilities; or

iv. Adventure programs that serve children with emotional and/or behavioral problems.

10:127-1.3 Definitions

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

"Adventure activity" means a planned activity of a wilderness or athletic nature that requires specially trained staff members and/or special equipment that is utilized with children to assist in their development of self-confidence and insight.

"Bureau" means the Bureau of Licensing of the Division of Youth and Family Services, New Jersey Department of Human Services.

"Chapter" means the rules contained in the Manual of Requirements for Residential Child Care Facilities, as specified in N.J.A.C. 10:127-1.1 to 10.25 and reflect provisions that constitute minimum baseline requirements below which no facility that is subject to the authority of N.J.S.A. 30:1-14 and N.J.S.A. 30:4C-4 is legally permitted to operate.

"Child" means any person who is under 18 years of age and/or any person between the ages of 18 and 21 who is under the supervision of the Division in placement in a residential child care facility.

"Denial of a certificate" means the withholding by the Bureau of an initial certificate of approval for which a facility has applied.

"Department" means the New Jersey Department of Human Services.

"Director" means the on-site staff member responsible for the daily operation and management of the facility.

"Division" means the Division of Youth and Family Services, New Jersey Department of Human Services.

"Exclusion" means removing a child to an area or room in the facility where there is limited stimulation. This removal shall be a therapeutic intervention and a time for the child to reflect on his or her behavior in order to gain control so he or she can return to the other children.

"Infant" means any person who is under the care of his or her adolescent mother in a facility serving adolescent mothers.

"Parent" means a birth or adoptive parent, legal guardian, or any other person having responsibility for, or custody of, a child.

"Person" means any individual, agency, corporation, company, association, organization, society, firm, partnership, joint stock company, the State or any political subdivision thereof.

"Placing agency" means an agency that assumes responsibility for payment of room and board for a child placed in a facility.

"Refusal to renew a certificate" means the non-issuance of a certificate of approval by the Bureau to a facility after its existing certificate has expired.

"Regular certificate of approval" or "regular certificate" means a document issued by the Bureau to a facility indicating that the facility is in full compliance with all applicable provisions of this chapter.

"Restraint" means the holding of a child so that he or she cannot move all or part of his or her body.

"Restrictive behavior management practice" means the use of restraint, exclusion, mechanical restraint and a behavior management room as part of a comprehensive treatment plan to help the child develop self-control, to reduce maladaptive behavior, to protect the child and others from harm or to prevent serious disruption to the therapeutic environment.

"Revocation of a certificate" means a permanent removal of a facility's current certificate of approval to operate.

"Shall" denotes a provision of this chapter that a facility must meet to qualify for a certificate of approval.

"Should" denotes a recommendation reflecting goals towards which a facility is encouraged to work.

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"Staff member" or "staff" means any person employed by or working for or at a facility on a regularly scheduled basis. This includes full-time, part-time, substitute, volunteer, student intern, contract or consulting personnel, whether compensated or not.

"Suspension of a certificate" means a temporary removal of a facility's current certificate of approval to operate.

"Temporary certificate of approval" or "temporary certificate" means a document issued by the Bureau, to a facility that is in substantial compliance with all applicable provisions of this chapter, provided that no serious or imminent hazard affecting the children exists in the facility.

SUBCHAPTER 2. APPROVAL PROCEDURES

10:127-2.1 Application for a certificate of approval

(a) No person shall operate a residential child care facility that provides board, lodging, care and treatment services for children who are placed or financed by the Division or by any other New Jersey State agency without first securing a certificate of approval from the Bureau, except for facilities that are subject to licensing or regulatory approval pursuant to State law by any other New Jersey State agency.

(b) A facility applying to the Bureau for an initial certificate of approval shall submit a completed application form to the Bureau, including the documentation specified in N.J.A.C. 10:127-4.1(a), (b) and (c), at least 45 calendar days prior to the anticipated opening of the facility.

(c) A facility applying to the Bureau for a renewal of its certificate of approval shall submit a completed application form to the Bureau, including the documentation specified in N.J.A.C. 10:127-4.1(d), at least 45 calendar days prior to the expiration of its existing regular certificate.

(d) The application form referenced in (b) and (c) above shall include the following:

1. General identifying information;
2. Name(s) of the sponsors;
3. Names of members of the governing boards;
4. A description of the agency's program, including program philosophy, goals and objectives;
5. A list of staff members; and
6. A list of residents placed by the Division.

10:127-2.2 Issuance of a certificate of approval

(a) The Bureau shall issue a regular certificate of approval to a facility that has achieved full compliance with all applicable provisions of this chapter.

(b) If the Bureau determines that a facility is in substantial compliance with, but does not meet all applicable provisions of, this chapter, and provided that there is no serious or imminent hazard to the education, health, safety, well-being or treatment needs of the children, the Bureau shall issue a temporary certificate to the facility and indicate in writing the steps the facility must take to secure a regular certificate of approval.

(c) A temporary certificate may be issued for a period not to exceed six months. The Bureau may issue as many temporary certificates as it deems necessary.

(d) Each certification period, which may include the issuance of one or more temporary certificates or one regular certificate, shall be two years.

1. In determining the expiration date of the first regular certificate of approval, the Bureau shall compute the two-year approval period from the date of issuance of the first temporary or regular certificate.

2. In determining the expiration date of a renewed regular certificate, the Bureau shall compute the two-year approval period from the date on which the previous regular certificate expired. If however, the facility has ceased to operate for a period of one year following the expiration date of its previous regular certificate, the Bureau shall compute the date of expiration from the date of issuance of a new certificate.

(e) The certificate of approval shall be issued to a specific facility and shall not be transferable.

(f) The facility shall maintain its certificate of approval on file.

(g) No facility shall make claims either in advertising or in any written or verbal announcement or presentation contrary to its approval status.

10:127-2.3 Denying, suspending, revoking or refusing to renew a certificate of approval

(a) The Bureau may deny, suspend, revoke or refuse to renew a certificate of approval for good cause, including, but not limited to, the following:

1. Failure to comply with the provisions of this chapter;
2. Violation of the terms and conditions of a certificate of approval;
3. Fraud or misrepresentation in obtaining a certificate;
4. Refusal to furnish the Division with files, reports, or records as required by this chapter;
5. Refusal to permit an authorized representative of the Division to gain admission to the facility or to conduct an inspection or investigation;
6. Any activity, policy, or staff conduct that adversely affects or is deemed by the Bureau to be detrimental to the education, health, safety, well-being or treatment needs of children or that otherwise demonstrates unfitness by the director or staff members of the facility to operate a residential child care facility;
7. Failure of an out-of-State facility to maintain a license, approval or certificate in its own state; and
8. Failure by the director to secure and maintain on file criminal conviction disclosures, as specified in N.J.A.C. 10:127-5.1(b)1.

(b) The Bureau shall provide written notice to the facility if it intends to deny, suspend, revoke or refuse to renew its application for a certificate. This notice shall specify the Bureau's reasons for such action and the need for the facility to come into compliance prior to such action being taken.

(c) If the Bureau denies, revokes, or refuses to renew a certificate of approval, as specified in (a) above, the facility shall be prohibited from reapplying for a certificate of approval for one year from the date of certificate denial, revocation or refusal to renew. After the one-year period has elapsed, the facility may submit to the Bureau a new application for a certificate.

(d) If a certificate is suspended, the Bureau shall issue or reinstate the certificate once the facility achieves compliance with the provisions of this chapter. In such a case, the Bureau shall not require the facility to submit a new application for a certificate unless such reapplication is expressly made a condition of the issuance or reinstatement of the certificate.

(e) Each certificate of approval issued by the Bureau to a facility remains the property of the State of New Jersey. If the Bureau suspends or revokes a certificate of approval, the facility shall return the certificate of approval to the Bureau immediately.

10:127-2.4 Administrative hearings

(a) If a facility fails to comply with all applicable provisions of this chapter, the Bureau shall issue a directive ordering compliance. Prior to the Bureau's decision to deny, suspend, refuse to renew or revoke a facility's certificate of approval, the facility shall have the opportunity to request an administrative hearing, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) As long as the Division determines that children are not at risk and that no imminent dangers exist, the Bureau may permit a facility that has requested an administrative hearing, as specified in (a) above, to continue to operate until a final decision is rendered as a result of the hearing.

10:127-2.5 Complaints

(a) Whenever the Bureau receives a report questioning the approval status or compliance of a facility or alleging a violation of this chapter, the Bureau shall ensure that the allegation is promptly investigated to determine whether the complaint is substantiated.

(b) If a serious complaint is received that alleges imminent hazard or risk to the health, safety and welfare of the children, the Bureau shall investigate the complaint within *[48]* ***24*** hours.

(c) After the report of the investigation has been completed, the Bureau shall notify the facility in writing of the results of the

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investigation within 15 days, pursuant to the State Public Records Law, N.J.S.A. 47:1A-1 et seq., with the exception of any information not permitted to be disclosed pursuant to the Child Abuse and Neglect Law, N.J.S.A. 9:6-8.10a, or any other State law.

(d) Whenever the Division, through its Bureau of Licensing, Institutional Abuse Investigation Unit or District Offices, conducts complaint investigations, the facility shall cooperate with all Division investigators.

10:127-2.6 Public access to the Bureau's licensing records

Licensing files maintained by the Bureau are public records and shall be readily accessible for examination by any person, under the direction and supervision of the Bureau, except when public access to records is restricted, in keeping with the State Public Records Law, N.J.S.A. 47:1A-1 et seq., or other applicable statutes.

SUBCHAPTER 3. ADMINISTRATION

10:127-3.1 Statement of purpose

(a) The facility shall maintain on file a written statement of purpose that shall identify the following:

1. The facility's philosophy, goals, and objectives;
2. Characteristics of the children to be served;
3. Types of treatment services provided to the children, including those provided directly by the facility and those provided in cooperation with community agencies or outside individuals;
4. Procedures for implementing those services; and
5. Criteria for completion of the program.

(b) The facility shall give this statement of purpose to the parents of the children being considered for services, and shall make it available to all staff members.

(c) The facility shall secure and maintain on file a record of the parents' and staff members' signatures attesting to their acknowledgment of the statement of purpose.

10:127-3.2 Rights of children

(a) The facility shall prepare a list of children's rights and shall post it in prominent locations in the facility, including in each living unit, or give it to the children and document such in each child's record. ***The list shall comply with the applicable provisions of N.J.S.A. 9:6B-1 et seq., the Child Placement Bill of Rights Act.*** At a minimum, the list shall specify the children's right to:

1. Receive prompt medical treatment;
2. Have access to an appropriate education;
3. Live in a safe, clean and healthy environment;
4. Be free of physical or sexual harassment or abuse and corporal punishment;
5. Attend religious services of their choice; and
6. Have unimpeded communication *[to]* ***with*** the Division ***and other professional persons or agencies***.

(b) The facility shall give this list of children's rights to the parents of the children being considered for admission and shall make it available to all staff members.

(c) The facility shall secure and maintain on file a record of the parents' and staff members' signatures attesting to their acknowledgment of the list of children's rights.

(d) If the facility chooses to develop a search and seizure policy, the facility shall give all children, staff and parents a copy of this policy, as specified in N.J.A.C. 10:127-6.15.

(e) The facility shall prepare, post or give to all staff members and children a written grievance procedure governing how the children may raise questions about or voice disagreements and concerns about procedures, care and specific incidents. The facility shall not take or threaten to take retaliatory or disciplinary action of any kind against a child who uses the grievance procedure. The facility shall provide a procedure to explain the above to children who are developmentally disabled***, unable to read or unable to hear***.

10:127-3.3 Information to parents and staff members

(a) The facility shall provide to every parent within five working days of his or her child's placement, and to every person upon becoming a staff member, a written document indicating that the facility is required to:

1. Secure a certificate of approval to operate from the Bureau of Licensing;
2. Comply with all applicable provisions of the manual;
3. Retain a current copy of the manual and make it available for review by parents of resident children;
4. Indicate how parents may secure a copy of the manual by contacting the Bureau of Licensing, Division of Youth and Family Services, CN 717, Trenton, New Jersey 08625-0717;
5. Afford parents the opportunity and time to review and discuss with the facility director any questions or concerns about policies, requirements, provisions, or alleged violations of the manual;
6. Advise parents that if they believe or suspect that the facility is in violation of any provision of the manual, they may report such alleged violations to the Bureau;
7. Make available, upon request, for parents' review the Bureau's Inspection/Violation and Complaint Reports on the facility, as well as any letters of enforcement or other actions taken against the facility during the current certificate of approval period;
8. Inform parents that they *[may request]* ***shall be provided*** a copy of the facility's behavior management policy, including policies for searches, as specified in N.J.A.C. 10:127-6.13*[, 6.14,]* and 6.15;
9. Inform parents that the facility is required to provide the child's parents with copies of the facility's visitation and communication policies, a copy of the procedures for expressing concern or registering complaints regarding their child's placement, and a description of its religious policies, including a statement that the child has a right to practice his or her religion;
10. Indicate through this document that any person who has reasonable cause to believe that a child residing in the facility has been or is being subjected to any form of hitting, corporal punishment, abusive language, ridicule, or harsh, humiliating or frightening treatment, or any other kind of child abuse, neglect or exploitation by any person, whether working at the facility or not, is required by State law to report such allegations to the Division's Office of Child Abuse Control*[.]***,*** TOLL FREE in New Jersey at 1-800-792-8610, or for out-of-State calls use (609) 292-8799 or any District Office immediately, and indicate that such reports may be made anonymously;
11. Indicate through this document how parents and staff members may secure information about the prevention and reporting of child abuse and neglect by contacting the Division;
12. Inform parents that the facility must secure written consent from the child's parents before the facility may involve the child in fund-raising, publicity, or audiovisual activities related to the facility; and
13. Inform parents that the facility will develop a visitation schedule for parents and children, as specified in N.J.A.C. 10:127-6.6, 9.20 and 10.13.

(b) The facility shall comply with the requirements specified in (a) above by:

1. Securing the parent's and staff member's signature on a record attesting to receipt of the document; and
2. Maintaining the record on file; or
3. If the parents cannot be reached or refuse to sign the document after repeated requests, the facility shall document in the record the attempts made to secure the parent's signature.

10:127-3.4 Community participation

(a) Each facility shall have a governing board that *[offers direction to the facility on its policies, staff recruitment and selection, physical environment, and program activities.]* ***is responsible for establishing and assuring the facility's mission, planning, and policies for finances, personnel, development and public relations. The governing board shall also be responsible for the facility's compliance with applicable laws and requirements.*** Such a board shall include representatives from the civic, business or educational community.

(b) The governing board shall meet at least every six months. The facility shall keep on file a list of current membership of the governing board and a record of its meetings.

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10:127-3.5 Conflict of interest

(a) Each facility receiving funds from the Division shall adopt a written conflict of interest policy, as required by the facility's contract with the Department of Human Services.

1. The facility shall ensure that a copy of the adopted policy, with its effective date, is forwarded to all governing board members and staff members and is posted in a prominent location or kept on file at the facility.

2. The governing board shall ensure that the conflict of interest policy is adhered to by the facility director through the governing board's review of the facility's policies involving the purchasing of goods or services and hiring practices.

10:127-3.6 Intake and admissions

(a) The facility shall ensure that the child and his or her parents have an opportunity to visit the facility prior to the child's placement.

(b) For all placements, the facility shall have the following information on file in the child's record upon the child's admission:

1. The child's full name, nicknames, if any, gender, date of birth, religion, and race;

2. The name, address, telephone number, and relationship to the child of the person(s) with whom the child was living at the time of admission;

3. The name, address, and telephone number of the child's father, mother, foster parents, or legal guardians, if different from (b)2 above;

4. The name, address, and telephone number of the case manager of the Division's District Office or other placing agency;

5. The name, address, and telephone number of the person to notify in an emergency;

6. The names of siblings, their ages, and gender;

7. The reason for placement of the child;

8. A Medicaid card, if applicable;

9. A Social Security Number, if available; and

10. A statement signed by the parent(s) or legal guardian, granting consent for emergency medical or surgical care, semi-annual dental care and annual physical examinations for the child.

(c) For all placements, the facility shall have the following information on file in the child's record within 30 calendar days of the child's admission:

1. Schools attended, grade level, and employer, if any;

2. Discharge summaries from previous placements, if any;

3. The child's medical history, including chronic conditions, past serious illnesses, allergies, medications, immunizations and special diet; and

4. A discharge plan, including the estimated duration of care.

(d) If the facility is unable to obtain the information specified in (c) above within 30 calendar days of the child's admission, the facility shall document in the child's file its efforts to obtain such information.

(e) Immediately following the child's admission, the facility shall:

1. Give each child a secure place to store valuables;

2. Ask the child to sign or otherwise verify that a staff member explained house rules and regulations, children's rights as specified in N.J.A.C. 10:127-3.2, discipline policy and search and seizure policy, if any; and

3. Inform each child of fire exits and evacuation procedures.

10:127-3.7 Reporting requirements

(a) The director or any staff member shall notify verbally the Office of Child Abuse Control or District Office immediately whenever there is reasonable cause to believe that a child has been or is being abused or neglected by staff members, children or any other person, as required by the New Jersey Child Abuse and Neglect Law, N.J.S.A. 9:6-8.9, 8.10, 8.13 and 8.14. Copies of the law and information about it are available from the Division, upon request.

(b) The facility shall notify the Bureau verbally of any of the following changes or events by the next working day after the facility learns of their occurrence, to be followed by written notification to the Bureau within five working days:

1. injury, accident or illness that results in the admittance of a child to a hospital;

2. The death of a child while the child was on the premises of the facility or in the care of a staff member or volunteer;

3. Temporary or permanent closing of the facility; and

4. Any criminal conviction of a staff member, as specified in N.J.A.C. 10:127-5.1(b).

(c) The facility shall notify the Bureau verbally of any of the following changes or events by the next working day after the facility learns of their occurrence:

1. The occurrence of a reportable disease, as specified in Chapter II of the State Sanitary Code, codified at N.J.A.C. 8:57;

2. Proposed relocation of the facility to a site not approved by local municipal officials and the Bureau, as specified in N.J.A.C. 10:127-4.1;

3. Damage to the premises of the facility caused by fire, accident or the weather; and

4. Proposed use of space involving rooms not approved by the Bureau, as specified in N.J.A.C. 10:127-4.1(a)5.

(d) The facility shall notify the Bureau in writing at least 30 calendar days before any of the following proposed changes or events:

1. The anticipated closing or relocation of the facility for any reason other than temporary closings for holidays and vacations;

2. A change or anticipated change of director of the facility;

3. A change of type of children served; or

4. A change of services offered.

(e) The facility shall notify the Division or the appropriate District Office and the child's parents within 24 hours of any unauthorized absence of a child from the facility. For out-of-state facilities, the phone number of the Office of Child Abuse Control is 1-609-292-8799.

10:127-3.8 Records

(a) The facility's records shall be open for inspection by authorized representatives of the Bureau, the Division's Institutional Abuse Investigation Unit (IAIU), the Division's contracting units and Division case managers provided that they may only secure information about children under the Division's supervision. ***The facility's records shall also be open to inspection by other agencies pursuant to applicable Federal and state laws, requirements or court order.***

(b) Each facility shall maintain on file the following administrative records until the expiration of its regular certificate of approval:

1. The following records shall be maintained in files located at the facility:

i. A copy of this chapter;

ii. A statement of purpose, as specified in N.J.A.C. 10:127-3.1 and 9.1;

iii. The Life/Safety and Program Inspection/Violation reports and Complaint Investigation Summary from the Bureau, if applicable, as well as letters of enforcement or other actions taken against the facility if applicable, that cover the current certificate of approval period;

iv. The document providing information to parents, as specified in N.J.A.C. 10:127-3.3(a);

v. A record of each parent's signature attesting to the receipt of the information to parents document, as specified in N.J.A.C. 10:127-3.3(b)1;

vi. Documentation of the use of extermination services, if applicable, as specified in N.J.A.C. 10:127-4.3(a)7;

vii. Policies and procedures regarding behavior management, as specified in N.J.A.C. 10:127-6.13, 6.14 and 10.14;

viii. A record of in-service training conducted for staff members, as specified in N.J.A.C. 10:127-5.4 and 10.3;

ix. A record of all incidents and accidents, recorded on incident and accident report forms, noting all details of the incident and accident and any actions taken by the staff members, as specified in N.J.A.C. 10:127-6.13, 7.3(b) and 9.3(a) and (b);

x. A copy of the comprehensive health plan, as specified in N.J.A.C. 10:127-7.1, 10.15 and 10.16;

xi. Copies of menus of food served to the children, including special diets, as specified in N.J.A.C. 10:127-6.11 and 10.24;

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xii. Aggregate statistical information on children served, including the date of each admission, date of each discharge, and reason for each discharge, as specified in N.J.A.C. 10:127-5.2(a)10;

xiii. A record of signed parental consent for children's participation in fund-raising, publicity, photography, or audiovisual activities related to the facility, as specified in N.J.A.C. 10:127-3.3(a)12;

xiv. A copy of the children's grievance procedures, as specified in N.J.A.C. 10:127-3.2(e);

xv. A record of signed parental consent for medical treatment for each child, as specified in N.J.A.C. 10:127-3.6(b)10;

xvi. A daily log book, in which an on-duty staff member shall comment on the activities and events of each day and staff member response to those events, as specified in N.J.A.C. 10:127-5.2;

xvii. A daily log book, a separate log book or notation in the child's case record, in which all visits to the child shall be recorded, as specified in N.J.A.C. 10:127-5.2;

xviii. A copy of the staff members' work schedules and time sheets, as specified in N.J.A.C. 10:127-5.2;

xix. A medication log book, as specified in N.J.A.C. 10:127-7.4, 7.5 and 10.20;

xx. A written daily schedule of planned recreational, leisure time and physical exercise activities, as specified in N.J.A.C. 10:127-6.8(b) and 10.11;

xxi. A record of pet vaccinations and the name and address of the licensed veterinarian providing care for the pets, if applicable, as specified in N.J.A.C. 10:127-6.12;

xxii. A copy of the parenting education curriculum, if applicable, as specified in N.J.A.C. 10:127-10.8;

xxiii. Documentation of the information received from the National Weather Service and park service, if applicable, as specified in N.J.A.C. 10:127-9.1(n) and (o);

xxiv. A copy of the plan for emergency evacuation procedures, if applicable, as specified in N.J.A.C. 10:127-9.2(a);

xxv. A copy of the plan for search and rescue procedures, if applicable, as specified in N.J.A.C. 10:127-9.2(b);

xxvi. Copies of biking permits, if applicable, as specified in N.J.A.C. 10:127-9.4(a);

xxvii. Documentation that permission was obtained to enter a cave from the owner or public authority, if applicable, as specified in N.J.A.C. 10:127-9.6(c);

xxviii. Documentation of the care of horses, if applicable, as specified in N.J.A.C. 10:127-9.8(d);

xxix. Documentation on the safety of ropes used in climbing, if applicable, as specified in N.J.A.C. 10:127-9.9(d);

xxx. A copy of the plan for boating activities, if applicable, as specified in N.J.A.C. 10:127-9.10(b);

xxxi. Copies of all permits, certificates or licenses for camping, if applicable, as specified in N.J.A.C. 10:127-9.15(a);

xxxii. A copy of the policy for treating snake, animal and insect bites and *[ingestion of or]* contact with poisonous plants, if applicable, as specified in N.J.A.C. 10:127-9.17(c);

xxxiii. A copy of the plan and procedures that enable children to receive an emergency message, and send and receive mail, if applicable, as specified in N.J.A.C. 10:127-9.20(c);

xxxiv. Documentation that children were permitted to make free telephone calls, if applicable, as specified in N.J.A.C. 10:127-9.20(e);

xxxv. A copy of the policy for visiting and communication for parents, if applicable, as specified in N.J.A.C. 10:127-9.20(g); and

xxxvi. A copy of the feed plan for horses, if applicable, as specified in N.J.A.C. 10:127-9.8 and 9.16.

2. The following records shall be maintained in files located either at the facility's administrative office or at the facility:

i. A record of comprehensive general liability insurance, as specified in N.J.A.C. 10:127-3.9;

ii. A record of performance of required monthly fire drills and/or evacuation drills, as specified in N.J.A.C. 10:127-4.5(c);

iii. A record of training sessions for staff members on evacuation procedures, the use of fire extinguishers, the location of fire alarms, and emergency medical procedures, as specified in N.J.A.C. 10:127-5.4(a)3;

iv. A copy of the facility's vehicle insurance policy, as specified in N.J.A.C. 10:127-8.2; and

v. Transportation records, if transportation is provided to children residing in the facility, as specified in N.J.A.C. 10:127-8.4.

3. For all facilities whose programs are primarily adventure based, the following records shall be maintained on location:

i. A copy of this chapter;

ii. The Life/Safety and Program Inspection/Violation Reports and Complaint Investigation Summary Reports from the Bureau, if applicable, as well as letters of enforcement or other actions taken against the facility, if applicable, that cover the current certificate of approval period;

iii. Policies and procedures regarding behavior management, as specified in N.J.A.C. 10:127-6.13, 6.14 and 10.14;

iv. A record of all incidents and accidents, recorded on incident and accident report forms, noting all details of the incident and accident and any actions taken by the staff members, as specified in N.J.A.C. 10:127-6.13, 7.3(b) and 9.3(a) and (b);

v. Copies of menus of food served to the children, including special diets, as specified in N.J.A.C. 10:127-6.11 and 10.24;

vi. A record of signed parental consent for children's participation in fund-raising, publicity, photography, or audiovisual activities related to the facility, as specified in N.J.A.C. 10:127-3.3(a)12;

vii. A record of signed parental consent for medical treatment for each child as specified in N.J.A.C. 10:127-3.6(b)10;

viii. A daily log book, in which an on-duty staff member shall comment on the activities and events of each day and staff member response to those events, as specified in N.J.A.C. 10:127-5.2;

ix. A copy of staff members' work schedules and time sheets, as specified in N.J.A.C. 10:127-5.2;

x. A medication log book, as specified in N.J.A.C. 10:127-7.4, 7.5, and 10.20;

xi. A written daily schedule of planned recreational, leisure time and physical exercise activities, as specified in N.J.A.C. 10:127-6.8(b) and 10.11;

xii. A copy of the plan for emergency evacuation procedures, as specified in N.J.A.C. 10:127-9.2(a); and

xiii. A copy of the plan for search and rescue procedures, as specified in N.J.A.C. 10:127-9.2(b).

(c) The facility shall maintain on file the following staff records throughout a staff member's employment and for one year after the staff member has stopped working at the facility:

1. The following records for the director and all staff members shall be maintained in files located either at the facility's administrative office or at the facility;

i. Applications for employment, with disclosure statement(s), as specified in N.J.A.C. 10:127-5.1(b) and 9.18;

ii. References on the director and staff members, as specified in N.J.A.C. 10:127-5.1(b) and 9.18;

iii. A record of each staff member's signature attesting to his or her receipt of the policy statement on the disciplining of children by staff members, as specified in N.J.A.C. 10:127-3.3(b);

iv. A record of each staff member's signature attesting to his or her receipt of the information to parents document, as specified in N.J.A.C. 10:127-3.3(b); and

v. Health information, as specified in N.J.A.C. 10:127-7.7.

2. The following staff records shall be maintained in files located at the facility:

i. Current staff member attendance sheets;

ii. Reasons for discontinuance of employment, if applicable, as specified in N.J.A.C. 10:127-5.1;

iii. A full written disclosure of the director's and every staff member's background, previous work experience and criminal convictions, if any, as specified in N.J.A.C. 10:127-5.1(b) and 9.18;

iv. Documentation that every staff member received and reviewed a copy of the facility's statement of purpose, grievance policy, children's bill of rights, fireplace policy, search and seizure policy, and information to parents statement, as specified in N.J.A.C. 10:127-3.1(b), 3.2(b) to (d), 3.3(b) and 4.4(c)6;

v. A written annual performance evaluation, as specified in N.J.A.C. 10:127-5.2; and

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vi. Documentation of training received by staff members, as specified in N.J.A.C. 10:127-5.4 and 10.3.

(d) The facility shall maintain on file the following children's records during the child's placement at the facility ***and*** for at least three years following the discharge of the child:

1. Identifying information, as specified in N.J.A.C. 10:127-3.6(b) and (c);

2. A copy of each treatment plan developed for the child as specified in N.J.A.C. 10:127-6.1 and a copy of the case management plan for facilities that serve pregnant and parenting adolescents, as specified in N.J.A.C. 10:127-10.4;

3. Education records, as specified in N.J.A.C. 10:127-6.7;

4. Reports of incidents, including, but not limited to, acts of aggression, violent or destructive behavior, discovery of contraband, suicidal threats, discovery of a weapon, inappropriate sexual behavior, involvement with the police and documentation of efforts made to locate runaways, as specified in N.J.A.C. 10:127-6.13, 6.14 and 6.15;

5. Reports of accidents, as specified in N.J.A.C. 10:127-7.3 and 9.3(a) and (b);

6. Documentation of the opening of a child's mail by facility staff *[member]*, as specified in N.J.A.C. 10:127-6.6;

7. Medical records, as specified in N.J.A.C. 10:127-7.2 and 9.17(a) and (b);

8. Explanations of medical treatment, as specified in N.J.A.C. 10:127-10.19;

9. A discharge summary, as specified in N.J.A.C. 10:127-6.2 and 10.5;

10. An aftercare plan, as specified in N.J.A.C. 10:127-6.2 and 10.5;

11. An infant's feeding schedule, as specified in N.J.A.C. 10:127-10.24;

12. Documentation that an adolescent mother received life skills development training, as specified in N.J.A.C. 10:127-10.25; and

13. Documentation that a child received information on adventure activities, as specified in N.J.A.C. 10:127-9.1(c).

(e) The facility shall ensure the confidentiality of the records for each child enumerated in (d) above, in accordance with New Jersey State law, including N.J.S.A. 9:6-8.10(a) covering abuse and neglect information. The facility shall ensure that all entries in the child's record indicate the entry date and the name and signature of the person making the entry.

10:127-3.9 Comprehensive general liability insurance

The facility shall secure comprehensive general liability insurance coverage and shall maintain on file a copy of the insurance policy.

SUBCHAPTER 4. PHYSICAL FACILITY REQUIREMENTS

10:127-4.1 Physical facility initial approval requirements for all facilities located in New Jersey

(a) An applicant seeking an initial certificate of approval, as specified in N.J.A.C. 10:127-2.1, to operate a facility located in New Jersey shall comply with all applicable provisions of the New Jersey Uniform Construction Code, as specified in N.J.A.C. 5:23 and hereinafter referred to as the NJUCC.

1. For newly constructed buildings, for existing buildings whose construction code use group classification would change from that which it had been, or for existing buildings that require major alteration or renovation, the facility shall submit to the Bureau a copy of a Certificate of Occupancy (CO) issued by the municipality in which it is located, reflecting the facility's compliance with provisions of the NJUCC, for one of the following use group classifications:

i. R-2 (Residential) for buildings accommodating children 2½ years of age and older for more than 30 calendar days and having a total occupancy of more than five and fewer than 16 children; or

ii. I-1 (Institutional) for buildings accommodating 16 or more children over 2½ years of age; or

iii. I-2 (Institutional) for buildings accommodating six or more children who are under 2½ years of age.

2. For facilities that are planning to construct a new building, the facility shall submit to the Bureau:

i. Preliminary architectural drawings for review and comment prior to beginning construction; and

ii. If applicable, revised architectural or final drawings containing all required items listed in the preliminary plan review for final approval from the Bureau before the facility can open.

3. For buildings constructed after the adoption of the NJUCC (1977), whose construction code use group classification is already R-2, I-1 or I-2 and that have not had major alterations or renovations since receipt of the CO, the facility shall obtain the CO issued by the municipality in which it is located at the time the building was originally constructed or approved for use in the NJUCC's R-2, I-1 or I-2 use group classification. The facility shall submit a copy of the building's CO to the Bureau.

4. For existing buildings, whose use prior to the adoption of the NJUCC (before 1977) was and continues to be for a children's residential facility and that have not had major alterations or renovations, the facility shall obtain a Certificate of Continued Occupancy (CCO) or a letter to this effect, issued by the municipality in which it is located, reflecting the *[buildings']* ***building's*** compliance with provisions of the municipality's construction code requirements that were in effect at the time it was originally constructed or converted for use as a facility. The facility shall submit a copy of the building's CCO or letter reflecting the building's compliance to the Bureau.

5. The facility shall obtain a new CO issued by the municipality in which it is located, reflecting the building's compliance with provisions of the applicable NJUCC use group classification, and submit a copy of the new CO to the Bureau whenever it takes any of the following actions:

i. Changes the building's use group classification to one other than the one prescribed on its original CO;

ii. Makes a major alteration or renovation, as defined by the NJUCC, of the building or premises where the facility is located;

iii. Increases the floor area or the number of stories to the building or premises where the facility is located; or

iv. Relocates to another site.

6. Whenever a municipality grants a facility a written variation from any of the requirements of the NJUCC, the Bureau may accept such variations as meeting the applicable requirements of this manual.

i. When the Bureau does not accept the variation, the non-acceptance shall be based on the best interests of the residents of the facility, and shall include consideration for their health and safety.

ii. Should the facility disagree with the Bureau, the facility may seek a hearing in accordance with N.J.A.C. 10:127-2.4(a) and the provisions of the Administrative Procedure Act, N.J.S.A. 52:14B-1, as implemented by the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) An applicant seeking an initial approval, as specified in N.J.A.C. 10:127-2.1, to operate a facility shall comply with all applicable provisions of the New Jersey Uniform Fire Code, as specified in N.J.A.C. 5:18, 18A and 18B and hereinafter referred to as the NJUFC. The facility shall obtain the building's fire safety inspection certificate issued by the municipality in which it is located, based on a fire inspection conducted within the preceding 12 months, reflecting the facility's compliance with all applicable provisions of the NJUFC. The facility shall submit a copy of the building's fire safety inspection certificate to the Bureau.

(c) An applicant seeking an initial approval, as specified in N.J.A.C. 10:127-2.1, to operate a facility shall comply with all applicable provisions of the State Sanitary Code, as specified in N.J.A.C. 8:24. The facility shall obtain a certificate or statement of satisfactory health approval issued by the applicable municipal, county or State health agency, based on a health inspection conducted within the preceding 12 months, certifying that the facility complies with applicable provisions of local, county and State health codes and poses no health hazard to the children served. The facility shall submit a copy of the certificate or statement of satisfactory health approval to the Bureau.

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(d) An applicant seeking the renewal of a certificate of approval to continue operating a facility shall obtain and submit to the Bureau, copies of:

1. A current fire safety inspection certificate for the building; and

2. A current certificate or statement of satisfactory health approval for the facility.

10:127-4.2 Physical facility initial approval requirements for all facilities located outside of New Jersey

(a) A facility located in a state other than New Jersey shall submit with each application documentation that the facility meets the provisions of all applicable codes governing building, fire, safety and health requirements in the state, county and municipality in which the facility is located.

(b) All facilities located in a state other than New Jersey shall also comply with the physical facility and life-safety requirements specified in N.J.A.C. 10:127-4, with the exception of N.J.A.C. 10:127-4.4(c), (f)3, (g), (h), (i), and (l).

10:127-4.3 Maintenance and sanitation requirements for all facilities

(a) The facility shall maintain all indoor areas in a safe and sanitary manner by ensuring that:

1. The facility is free of moisture resulting from water leaks or seepage;

2. All lally columns in areas used by the children have protective padding from the floor to a height of at least 72 inches;

3. Floors, walls, ceilings and other surfaces are kept clean and in good repair;

4. Stairways are free of hazards such as boxes, loose steps, torn carpeting or raised strips;

5. Carpeting is secured to the floor;

6. Garbage and food receptacles are:

i. Made of durable, leakproof and nonabsorbent materials;

ii. Covered in a secure manner;

iii. Emptied to the outdoor garbage receptacle when filled; and

iv. Lined and maintained in a sanitary manner;

7. The facility is free of rodent or insect infestation. If there is evidence of rodent or insect infestation, immediate action shall be taken to remove such infestation. The facility shall maintain on file a record documenting the use of extermination services in these cases;

8. Toilets, wash basins, kitchen sinks, and other plumbing are maintained in good operating and sanitary condition;

9. All corrosive agents, insecticides, bleaches, detergents, polishes, any products under pressure in an aerosol can, and any toxic substances are stored in a locked cabinet or in an enclosure located in an area not accessible to children. Bleaches, detergents, polishes and specific aerosol products may be made available to children 12 years of age and older with facility supervision;

10. Ventilation outlets are clean and free from obstructions, and filters are replaced when saturated;

11. Walls are painted or otherwise covered whenever there is evidence of:

i. Excessive peeling or chipped paint; or

ii. Heavily soiled conditions; and

12. All shelving is secured and not overloaded.

(b) The facility shall maintain all outdoor areas in a safe and sanitary manner by ensuring that:

1. The building, land and outdoor play area are free from any hazards to the health, safety or welfare of the children;

2. The outdoor play area is graded or provided with drains to dispose of surface water;

3. The building structure is maintained to prevent:

i. Water from entering;

ii. Excessive drafts or heat loss; and

iii. Infestation from rodents and insects;

4. The railings of balconies, landings, porches, or steps are maintained in safe condition;

5. Garbage receptacles are:

i. Made of durable, leakproof and nonabsorbent materials; and

ii. Covered in a secure manner, maintained in a sanitary manner and located in an outdoor area; and

6. All fencing or other natural or man-made barriers or enclosures, shall be maintained in proper condition.

(c) The Bureau shall also require the facility to take whatever steps are necessary to correct any conditions in the facility that may endanger in any way the health, safety and well-being of the children served.

10:127-4.4 Additional maintenance and sanitation requirements for all facilities located in New Jersey

(a) The facility shall meet the following lighting requirements:

1. All fluorescent tubes and incandescent light bulbs shall have protective covers or shields;

2. During activities in the facility, at least 20 foot-candles of natural or artifical light shall be provided in all rooms used by the children. This illumination shall be measured three feet above the floor at the farthest point from the light source; and

3. Parking areas, pedestrian walkways, or other exterior portions of the premises subject to use by children and staff at night shall be illuminated to provide safe entrance to and egress from the facility.

(b) The facility shall meet the following heating requirements:

1. A minimum temperature of 65 degrees Fahrenheit shall be maintained in all rooms used by the children;

2. Working fireplaces, steam and hot water pipes, radiators and electric space heaters shall be protected by screens, guards, insulation or any other suitable, non-combustible protective device; and

3. The facility shall not use portable liquid fuel-burning or wood-burning heating appliances.

(c) The facility shall ensure that fireplaces meet the following requirements:

1. The use of a fireplace for the children served by the facility shall not pose a serious risk of fire hazard to occupants of the facility, as determined by the local fire official;

2. The fireplace shall be approved by the local government construction official and fire official, in accordance with applicable provisions of the NJUCC and the NJUFC, respectively;

3. The facility shall obtain a copy of these certificates or statements of approval and submit them to the Bureau;

4. The facility shall develop guidelines, in conjunction with the local fire official, that ensure proper use of the fireplace, safety procedures, and an action plan to be followed in the event of an emergency;

5. The guidelines specified in (c)4 above shall include, but not be limited to, staff member supervision, storage of wood, storage and safeguarding of matches, instruction in the use of fireplace implements, use of the screen, posting of emergency phone numbers for police and fire departments and hospitals, posting of emergency procedures and exits, and methods and safeguards for extinguishing the fire; and

6. The guidelines specified in (c)4 above shall be maintained on file by the facility and reviewed by all staff members and children in the facility.

(d) The facility shall meet the following ventilation requirements:

1. Crawl spaces, attic spaces, and all doors and windows used for natural ventilation shall have insect screening;

2. All floor or window fans that are accessible to the children shall have a grille, screen, mesh or other protective covering designed to prevent a child from coming into contact with the blades of the fan; and

3. Ventilation outlets shall be clean and free from obstructions and filters shall be replaced when saturated.

(e) The facility shall ensure that mirrors, dispensers, and other equipment are fastened securely.

(f) Facilities that serve children with special needs shall ensure that:

1. For non-ambulatory children, the toilet facilities are located on the same floor where the children's bedrooms and activities are located;

2. The width and height of toilets and sinks accommodate the children served; and

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3. Grab bars are provided in toilet and bathroom areas, as specified in N.J.A.C. 5:23-7, the Barrier-free Subcode of the NJUCC.

(g) The facility shall not use lead paint on and shall remove lead paint from any interior or exterior surfaces of a building used as a facility, or on any furniture, toys or other equipment used therein, in accordance with the provisions of the State Lead Paint Law, pursuant to N.J.S.A. 24:14A-1 et seq., and with the provisions of the State Sanitary code, as specified in N.J.A.C. 8:51-7. When lead paint is found in areas of a facility not specified in N.J.A.C. 8:51-7, the Bureau shall determine whether the lead paint is hazardous to the health, safety and well-being of the children served and, if considered to be hazardous, the facility shall remove the lead paint hazard.

(h) The facility shall not use spray coatings containing asbestos on any interior or exterior surfaces of the facility or on any equipment used therein, in accordance with rules of the State Department of Environmental Protection, as specified in N.J.A.C. 7:27-17.2 and with applicable provisions of the Asbestos Hazard Abatement Subcode of the NJUCC, as specified in N.J.A.C. 5:23-8. If the New Jersey Department of Health determines the presence of sprayed-on asbestos-containing materials, and concludes that corrective action must be taken to minimize exposure potential, the facility shall follow the recommendation of the State Health Department for enclosure, removal or other appropriate action to remove the threat or risk of asbestos contamination.

(i) The facility shall ensure that swimming pools and natural bathing places used by the children:

1. Comply with applicable provisions of the Public Recreational Bathing Rules, as specified in N.J.A.C. 8:26, and with applicable provisions of the Building Subcode and Barrier-free Subcode of the NJUCC, as specified in N.J.A.C. 5:23; and

2. Provide for supervision of the children, in accordance with applicable provisions of the New Jersey Youth Camp Safety Act rules, as specified in N.J.A.C. 8:25.

(j) The facility shall ensure that materials and furniture for indoor and outdoor use are of sturdy and safe construction, easy to clean and free of hazards that may be injurious to children.

(k) The facility shall ensure that toilet facilities meet the following requirements:

1. At least one toilet, wash basin and bath tub or shower is provided for every six children in the facility. These facilities shall not be located more than one floor from any bedroom; and

2. A supply of hot tap water not exceeding 110 degrees Fahrenheit and cold running water is provided.

(l) A facility utilizing a kitchen facility or food preparation area shall ensure that the cooking equipment and kitchen facility are kept clean and sanitary and are operated in compliance with applicable provisions of Chapter XII, State Sanitary Code, as codified at N.J.A.C. 8:24.

(m) The facility shall obtain prior approval from the Bureau for all space used by the children.

(n) The facility shall not care for more children than the number specified in the certificate of approval.

(o) The facility shall meet the following space requirements to ensure the safety, treatment, recreational, dining and sleeping needs of the children, including:

1. Adequate space for the implementation of treatment services, including individual, group and family counseling sessions and treatment team meetings;

2. A recreation room or area that can accommodate indoor individual or group activities;

3. A dining area large enough to accommodate tables and chairs for all the children; and

4. Rooms for sleeping:

i. Any bedroom used by a child shall have a minimum ceiling height of seven feet and six inches.

ii. Any bedroom containing a single bed occupied by one child shall provide a minimum of 70 square feet of floor space, including space that is occupied by furniture.

iii. Any bedroom containing two or more single beds and occupied by more than one child shall provide a minimum of 70 square feet of floor space for the first child and 50 square feet of floor space for each additional child, including space that is occupied by furniture.

iv. Any bedroom containing bunk beds or any combination of single beds and bunk beds shall provide 50 square feet of floor space for each child, including space that is occupied by furniture.

10:127-4.5 Emergency evacuation instructions, medical emergencies, fire prevention, first aid and equipment

(a) The facility shall prepare and post on each floor written emergency evacuation instructions that include:

1. A diagram showing how the facility is to be evacuated in the event of an emergency; and

2. The location of fire alarms and fire extinguishers.

(b) The facility shall maintain the following information near a staff telephone or other accessible area for use in the event of ***a*** medical emergency:

1. The name, address and telephone number of the physician retained by the facility or of the health facility to be used in emergencies;

2. The location of written authorizations from parents for emergency medical care for each child;

3. The procedure for obtaining emergency transportation;

4. The procedure for obtaining substitute or on-call supervision, if needed;

5. The telephone numbers of the local police, fire department, ambulance service and poison control centers; and

6. The location of the first aid kit and any additional first aid supplies.

(c) The facility shall prepare written fire prevention instructions, which specify that:

1. The facility shall conduct fire drills at least once a month, which shall include all staff members and children, and shall inform all staff members and children of the procedures for leaving the building in an emergency situation;

***i. Fire drills shall be conducted on all shifts; and**

**ii. Evacuations should be completed within three minutes. If evacuations are not completed within three minutes, the facility should contact its local fire official for assistance with improving its evacuation time.***

2. The facility shall maintain on file a record of each fire drill, which shall include:

i. The date and time of the drill;

ii. The weather condition at the time of evacuation;

iii. A notation of any problems encountered during the drill;

iv. The number of participating children and staff members;

v. The total amount of time taken to evacuate the facility; and

vi. The signature of the staff members conducting the drill.

3. Each facility shall ensure that fire protection requirements, including those for boiler/furnace separation, electrical fire alarm systems, emergency lighting and exit signs conform to all applicable provisions of the NJUFC and the NJUCC; and

4. The facility shall ensure that all staff members are trained in the use and operation of fire extinguishers.

(d) The following equipment shall be placed in a location that is convenient and accessible to staff members:

1. A standard first aid kit, which is fully restocked within 24 hours of use; and

2. The American Red Cross First Aid Manual or its equivalent.

10:127-4.6 Special requirements for staff members, children, visitors or family members who use tobacco products

(a) If the facility permits the smoking of tobacco products or the use of smokeless tobacco, the facility shall designate *[one area or room within the facility or]* an outside area where staff members, children, as identified in (d) below, visitors or family members may use tobacco products.

(b) The facility shall prohibit the smoking of tobacco products or the use of smokeless tobacco in:

*[1. The presence of infants and toddlers;

2. Bedrooms used by children and staff members;

3. Dining areas when children are participating in meals;

4. Kitchen areas when meals are being prepared; and

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5. Administrative and staff offices when children are present.]*

***1. All buildings used by children; and**

**2. All vehicles used by the facility when children are passengers, as specified in N.J.A.C. 10:127-8.1(d).***

(c) The facility shall ensure that staff members comply with the provisions of N.J.S.A. 2A:170-51, which prohibits them from directly or indirectly selling, giving or furnishing to a minor under 18 years of age any cigarettes made of tobacco or any other matter or substance *[than]* ***that*** can be smoked, or any cigarette paper or tobacco in any form, including smokeless tobacco.

(d) The facility may permit children who smoke tobacco products or use smokeless tobacco to continue to do so, provided that the following conditions exist:

1. The child shall only be permitted to smoke tobacco products or use smokeless tobacco in the designated area *[or room identified in (a) above]* ***outside the building(s)***;

2. The treatment team shall develop goals that will direct, guide and counsel the child to stop smoking tobacco products or using smokeless tobacco; and

3. The child shall be provided with written and verbal information that outlines the *[serious health hazards]* ***health and social consequences*** stemming from smoking tobacco products or using smokeless tobacco.

(e) The facility shall not utilize tobacco products as a reward in its behavior management program or in any of its policies or practices.

SUBCHAPTER 5. STAFF REQUIREMENTS

10:127-5.1 General requirements for director and all staff members

(a) The director and every staff member shall:

1. Be of good character and reputation;

2. Be in sufficient physical, mental and emotional health to perform his or her job duties satisfactorily; and

3. Possess skills, attributes and characteristics conducive to and suitable for operating a facility or dealing with children, as applicable.

(b) Prior to hiring or utilizing a director or a staff member who will be working at the facility, the facility shall secure and maintain on file:

1. A signed application for employment from each individual, indicating the applicant's name, address and telephone number, education and work experience, and disclosure of the presence or absence of criminal convictions. The employment application shall be updated to indicate the reasons for discontinuance of employment, if applicable; and

2. Two written or two verbal references on each individual. These references shall be secured from former employers or other persons who have knowledge of the individual's work experience or education and who can attest to the individual's suitability to work with children. The verbal references shall be documented in writing by the facility.

(c) Failure by the director or other staff member to comply with the requirements specified in (a) and (b) above, and/or any evidence demonstrating unfitness or unsuitability to fulfill the responsibilities and duties of his or her position or to serve or deal with children in an appropriate manner, shall constitute grounds for one or more of the following actions:

1. Removal of the director or staff member from his or her position by the governing board;

2. Reassignment to other duties that do not involve contact with children;

3. Termination from the facility; or

4. Denial, refusal to renew, suspension or revocation of the facility's certificate of approval by the Bureau.

(d) Evidence of conviction for crimes of violence, felonies, illegal substance abuse or child abuse and neglect shall be among those actions that are considered in determining an individual's suitability to serve as director or staff member in a facility.

(e) Evidence of conviction of a crime, in and of itself, shall not automatically preclude an individual from serving as director or staff member or from working in the facility and shall not automatically result in the removal or termination of a director or staff member. The facility shall submit a written justification to the Bureau, indicating and documenting why it feels the individual at issue should not be precluded from working or holding a leadership position at the facility. The Bureau, after assessing the facts on a case by case basis, shall make the final determination, in keeping with the provisions of the State Rehabilitated Convicted Offenders Act, N.J.S.A. 2A:168A-1 et seq., which provides that a person convicted of a crime may not be disqualified or discriminated against by a licensing authority unless the conviction relates adversely to the occupation, trade, vocation, profession or business for which the license is sought.

(f) The facility shall disclose to the Bureau, in writing, information about and circumstances surrounding any previous denial, suspension, revocation or refusal to renew a certificate of approval or a license to operate a facility either by the Bureau or by the licensing agency of another state. Evidence of a previous denial, suspension, revocation or refusal to renew a certificate of approval or license, shall not in and of itself result in an automatic disqualification of the prospective facility to secure a certificate of approval for another or the same facility, but shall constitute grounds for the Bureau to investigate the circumstances that led to the original negative action and make a determination as to whether to reject or process the new application for a certificate of approval.

(g) Requirements to prevent child abuse or neglect are as follows:

1. The director or any staff member shall verbally notify the Division's Office of Child Abuse Control or appropriate District Office immediately whenever there is reasonable cause to believe that a child has been subjected to abuse or neglect by a staff member, or any other person other than the child's parent or family member, pursuant to the State Child Abuse and Neglect Law (N.J.S.A. 9:6-8.9, 8.10, 8.13 and 8.14). This provision shall also apply to facilities located outside of New Jersey, notwithstanding the child abuse and neglect provisions of the state in which the facility is located;

2. The facility shall report any suspected abuse or neglect of the child by his or her parents or other family members to the Division case manager/supervisor assigned to the family;

3. When reporting to the Division as specified in (g)1 above, the facility shall also notify the parent(s) of the incident(s) reported which might indicate possible abuse or neglect involving the child. Such notification shall be made on the same day on which the incident(s) occurred. The facility shall maintain on file a record of such incident(s) and documentation that the parent(s) have been informed of them;

4. The Division, during the course of investigating an allegation of child abuse and neglect, may determine that immediate, corrective action is necessary to protect the children whenever:

i. The director or staff member has been found by the Division's Institutional Abuse Investigation Unit (IAIU) to pose a risk of harm to children;

ii. The director or staff member has committed an act of child abuse or neglect, as substantiated by the IAIU; or

iii. The director or staff member has been convicted of such acts;

5. Whenever the IAIU makes such a determination, the governing board or director shall carry out the Division's recommendation for immediate remedial action and long term corrective action. Such remedial action may include, but not be limited to:

i. Removal or suspension of the affected director or staff member from the facility or reassignment to other duties that do not involve contact with the children; or

ii. When the director or staff member resides at the facility, removal of the affected employee from the premises;

6. Such suspension, removal or reassignment, as specified in (g)5 above, shall remain in effect until the results of the Division's investigation have been determined, and a final decision in the matter has been rendered by the Division; and

7. Substantiation of the child abuse and neglect allegation by the Division's IAIU shall not, in and of itself, automatically result in the termination of the accused director or staff member from his or her position in the facility, but shall constitute grounds for possible termination if the person's continued employment at the facility would place the children at risk. Such determination shall be made

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by the Bureau after considering information provided by the agency, the director, the affected staff member, the IAIU and law enforcement authorities, as applicable.

(h) The facility shall utilize medical, dental, and psychological personnel serving children on either a staff or community provider basis who shall:

1. Be responsible for ensuring that the medical, dental, and psychological needs of the children are met; and

2. Be licensed to practice in the state where the staff member or community provider is located, as required by the laws of that state.

10:127-5.2 Staff qualifications

(a) Residential child care facilities shall have a full-time administrator or director, social service staff, teaching staff members (if the facility provides an on-grounds educational program), medical and nursing staff, child care staff, a staff member(s) designated to plan and implement the facility's recreational program, a staff member(s) designated to direct and be responsible for food services, and staff who shall be responsible for daily housekeeping and maintenance.

(b) The full-time administrator or director of the facility shall:

1. Be at least 21 years of age;

2. Have one of the following qualifications:

i. A bachelor's degree in social work, psychology or a related field from an accredited college or university and four years of professional experience in the human services field, two of which shall have been in a supervisory or administrative position;

ii. A master's degree from an accredited graduate school in social work, psychology or a related field and three years of professional experience in the human services field; or

iii. For publicly operated facilities, meet the requirements of the State Department of Personnel for the position, if applicable;

3. Be responsible for implementing the overall planning, operation, and management of the facility, including the facility's recreational and food programs;

4. Designate staff members to be in charge at all times during his or her absence;

5. Be on call to assist the staff in admissions, emergencies, and/or other responsibilities;

6. Be responsible for ensuring that all staff members receive an annual performance evaluation;

7. Be responsible for ensuring that all staff members' work schedules and time sheets are maintained;

8. Be responsible for ensuring that a daily log book, separate log book, or the child's case record contains a written notation of all visits to children;

9. Be responsible for ensuring that on-duty staff members complete entries in the daily log book that reflect the activities and events of each day; and

10. Be responsible for maintaining aggregate statistical information on children served, including the date of each admission, date of each discharge, and reason for each discharge.

(c) The social services/clinical director of the facility shall:

1. Be at least 21 years of age;

2. Have one of the following qualifications:

i. A bachelor's degree in social work, psychology or a related field from an accredited college or university and three years of professional clinical experience in the human services field, one year of which shall have been in a supervisory or administrative position; or

ii. A master's degree from an accredited graduate school in social work, psychology or a related field and two years of professional experience in the human services field; or

iii. For publicly operated facilities, meet the requirements of the State Department of Personnel for the position, if applicable;

3. Ensure that any staff member or consultant that utilizes the title or designation of social worker, licensed clinical social worker, licensed social worker, certified social worker, medical social worker, social work technician or any other title or designation which includes the words social worker, or any abbreviations such as SW, LCSW, LSW, CSW or SWT, is certified or licensed pursuant to N.J.S.A. 45:15BB-1 (Social Workers Licensing Act of 1991);

***i. All facilities located in a state other than New Jersey shall ensure that social work staff and social work supervisors are certified or licensed pursuant to that state's laws or requirements, if applicable;**

**ii. All facilities located in New Jersey shall ensure that staff members who function as social workers or social work supervisors and can meet the education and experience requirements to be licensed or certified, but are not currently licensed or certified, obtain the appropriate license or certificate within the time frames prescribed by N.J.S.A. 45:15BB-1 et seq.;**

**iii. A facility located in New Jersey may require existing staff members who function as social workers or social work supervisors and who do not currently meet the education and experience requirements to be licensed or certified pursuant to (c)3 above, to obtain the appropriate certificate or license as a condition of continued employment; or it may retain such staff members in the same capacity so long as these staff members are not utilizing titles specified in (c)3 above; and**

**iv. All facilities located in New Jersey shall ensure that all new staff members that are hired for the positions of social worker and social work supervisor are licensed or certified as specified in (c)3 above.***

4. Be responsible for the overall treatment planning for children;

5. Provide support and technical assistance to the social services staff; and

6. Provide clinical supervision to staff and ensure that social services staff receive job performance evaluations.

(d) Each social service worker shall:

1. Be at least 21 years of age;

2. Provide services for children as outlined in the treatment plan; and

3. Have one of the following qualifications:

i. A bachelor's degree in social work, psychology or a related field from an accredited college or university and one year of professional experience in the human services field;

ii. A master's degree from an accredited graduate school in social work, psychology or a related field; or

iii. Meet the requirements of the State Department of Personnel for the position, if applicable.

(e) The child care director of the facility shall:

1. Be at least 21 years of age;

2. Have one of the following qualifications:

i. A bachelor's degree in the human services field from an accredited college or university and three years of professional experience in the human services field, two years of which shall have been in a supervisory or administrative position in a residential child care facility, group home or children's shelter;

ii. A master's degree from an accredited graduate school in the human services field and one year of professional experience in the human services field in a residential child care facility, group home or children's shelter; or

iii. For publicly operated facilities, meet the requirements of the State Department of Personnel for the position, if applicable;

3. Be responsible for the daily operation of the child care program; and

4. Ensure that all child care staff receive job performance evaluations*[:]**.*

(f) Each child care staff member shall:

1. Be at least 18 years of age;

2. Provide daily care and supervision of the children;

3. Inform the social service staff members or director of any incidents that may impact on the child's treatment planning, as specified in N.J.A.C. 10:127-6.1 and 6.2; and

4. Have one of the following qualifications;

i. A high school or high school equivalency diploma and one year of experience working with children in a group setting;

ii. An associate's or bachelor's degree from an accredited college or university in a field that is unrelated to social work or psychology and six months experience working with children in a group setting;

iii. An associate's or bachelor's degree from an accredited college or university in social work, psychology or a related field; or

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iv. Meet the requirements of the State Department of Personnel for the position, if applicable.

(g) Each staff member designated to plan and implement the facility's recreational program shall:

1. Be at least 21 years of age;

2. Meet the qualification(s) for child care staff as specified in (f) above; and

3. Have at least three years experience in planning or implementing recreational activities for children in residential child care centers, group homes, children's shelters, children's camps or Boy Scouts/Girl Scouts.

(h) Education staff of the facility including administrative, supervisory and teaching staff shall comply with the staff qualifications, certifications, licenses and experience requirements of the New Jersey Department of Education or the equivalent agency in the state where the facility is located.

(i) Each physician, nurse, dentist, psychologist, speech therapist, physical therapist and occupational therapist employed by the facility or providing services on a contracted basis to the facility shall:

1. Be licensed/credentialed to practice in the state where the staff member or community provider is located, if required by the laws of that state; and

2. Be responsible for ensuring that the needs of the children for medical, dental, psychological, psychiatric or other services are met.

(j) Each staff member designated to direct and be responsible for providing food services shall:

1. Be registered or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association or meet the applicable requirements established by the state where the facility is located;

2. Meet the requirements of the Child Nutrition Program;

3. Have a bachelor's degree from a college or university with a major in foods, nutrition, food service or institution management, or the equivalent course work for a major in the subject area; and have completed a dietetic internship accredited by the American Dietetic Association or a dietetic traineeship approved by the American Dietetic Association or have one year of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting;

4. Have a master's degree plus six months of full-time, or full-time equivalent experience in nutrition and/or food service management in a health care setting; or

5. Develop a plan approved by a dietician or dietary consultant who meets the qualifications specified in (j)1 through 4 above.

10:127-5.3 Staff to child ratios

(a) Each residential child care facility shall meet the following staff to child ratios:

1. The facility shall have a social services/clinical director when its capacity is more than 80 children;

2. The facility shall have a child care director when its capacity is more than 50 children;

3. There shall be at least one social services worker for every 20 children;

4. There shall be at least one full-time nurse at a facility that serves at least 35 children. A facility that serves fewer than 35 children shall have at least access to a part-time nurse;

5. There shall be at least one child care staff member for every six or fewer children during the waking hours;

6. During sleeping hours, there shall be at least one child care staff member in each living unit in the facility and at least one additional staff member awake and on-duty for each 50 children or fraction thereof, in the facility; and

7. There shall be at least one child care staff member awake and on-duty in living units that are co-educational during sleeping hours.

(b) A facility that has a capacity of 30 or fewer children may utilize the administrator/director of the facility to serve as the director of one other program area, provided that such person meets the qualifications for that position.

10:127-5.4 Staff training and development

(a) The facility shall develop a training plan and the director shall ensure that all staff members, upon employment, are trained in:

1. The facility's statement of purpose, as specified in N.J.A.C. 10:127-3.1;

2. The facility's behavior management policy and search and seizure policy, if any, as specified in N.J.A.C. 10:127-6.14 and 6.15;

3. Emergency procedures, as specified in N.J.A.C. 10:127-4.5(a), (b) and (c);

4. Protocols for medication, as specified in N.J.A.C. 10:127-7.4 and 7.5;

5. Infection control procedures, as specified in N.J.A.C. 10:127-7.8;

6. The facility's techniques for safe physical and mechanical restraint, if applicable, as specified in N.J.A.C. 10:127-6.13(i) and (k);

7. The facility's policy and procedures for utilizing a behavior management room, if applicable, as specified in N.J.A.C. 10:127-6.13(m); and

8. The facility's policy and procedures for utilizing exclusion, as specified in N.J.A.C. 10:127-6.13(j).

(b) The facility shall ensure that every new staff member is accompanied on his or her duties by an experienced staff member as part of an orientation, until the new staff member is familiar with daily routines and operations of the facility.

(c) The facility shall document in each staff member's record that all social service and child care staff members, including full and part-time staff members, receive a minimum of a total of 12 hours of training each year in the following areas:

1. The principles of behavior management;

2. Alcohol***, tobacco*** and substance abuse;

3. Human sexuality and AIDS; and

4. Suicide prevention.

(d) The facility's training plan may include in-depth discussions at staff meetings, attendance at workshops, conferences or relevant college courses.

10:127-5.5 Volunteers and student interns

(a) The facility may use volunteers or student interns to support the activities of regular paid staff members, but shall not use volunteers or student interns to substitute for paid staff members.

(b) The facility shall ensure that volunteers and student interns are briefed fully on any special needs or problems they might encounter while working with the children.

(c) The facility shall ensure that volunteers and student interns who have contact with children or parents receive an orientation to the facility's program and are supervised by paid staff members. Volunteers and student interns shall receive authorization from the facility prior to accompanying children off-grounds *[to]* ***on*** trips, medical appointments and visits.

(d) The facility shall require an application, disclosure and references, as specified in N.J.A.C. 10:127-5.1(b)1 and 2, for volunteers and student interns who provide activities or transportation to a child by themselves.

SUBCHAPTER 6. PROGRAM REQUIREMENTS

10:127-6.1 Treatment plan for children in residential child care facilities

(a) The facility shall develop, implement and maintain on file a written individual treatment plan for each child. The plan shall delineate how to meet that child's needs and to remediate the problems and behavior in order to assist the child in completing the program.

(b) The facility shall form a treatment team that is responsible for the development of a treatment plan for each child. The treatment team shall consist of each of the following:

1. Staff members representing the clinical and social work components;

2. Staff members representing the child care component;

3. Staff members representing the administration of the facility, if necessary;

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4. Representatives from the child's responsible school district and/or current school district, if necessary;

5. The Division's case manager; and

6. The child's *[parents, if appropriate.]* ***parent(s), unless there is an explicit legal or medical basis to exclude them.***

(c) The facility shall document in the child's record that the Division's case manager or other placing agency, the child's therapist, parents or legal guardian and the child's responsible and/or current school district, if appropriate, were invited to participate as members of the treatment team and assist in the development of the treatment plan and all subsequent revisions.

(d) The facility shall develop the initial treatment plan within 30 calendar days following a child's admisssion, commence with the treatment plan for three months, then review or revise the treatment plan at least every six months thereafter.

(e) The treatment plan shall include the following information:

1. The name of the child;

2. The date of the child's admission;

3. The date when the plan is developed or revised;

4. The names and titles of all persons attending the development or review meeting;

5. The child's social, familial, emotional, behavioral, and academic strengths and weaknesses;

6. A statement of who can and cannot visit the child (if applicable), and the reason(s) why;

7. Specific treatment goals and ***measurable*** objectives in each program area and projected time frames for completing each goal and objective;

8. The name of the staff member responsible for ***the*** implementation of ***techniques to be used to achieve*** each treatment goal and objective;

9. *[Techniques]* ***The techniques*** to be used to achieve each treatment goal and objective;

10. Criteria to be used to determine whether each treatment goal is achieved;

11. A notation of progress made from the previous plan;

12. Documentation of efforts to achieve timely discharge, including, but not limited to, services needed by parents or other persons to whom the child will be discharged; and

13. For children who are 14 years of age or older, how the child is being prepared for self-sufficiency. This information may be documented in the child's individual education plan (I.E.P.). The documentation shall include, but not be limited to, instruction in:

i. Food preparation;

ii. Budgeting and money management; and

iii. Vocational planning and employment search efforts.

(f) The facility shall send to the Division's case manager or other placing agency a copy of the treatment plan and any revisions to it within 30 calendar days after the treatment planning meeting and retain a copy of the plan in the child's record for at least three years after the child's discharge.

(g) The facility shall ensure that the child's treatment plan and any revisions to it are explained to the child, his or her parents, and all staff members responsible for the plan's implementation. If the facility does not explain the child's treatment plan to the child's parents, the facility shall document in the child's case record the reasons why the plan was not explained to the parents.

10:127-6.2 Discharge planning

(a) For discharges that can be anticipated, the facility shall develop a plan with the Division's case manager or other placing agency staff at least 30 days before the child's discharge. The plan shall be sent to the Division's case manager or other placing agency and shall specify the following information:

1. The date of admission;

2. The anticipated or actual date of discharge;

3. Details of the events and circumstances leading to the decision to discharge;

4. The name and address of the individual or agency to whom the child will be discharged and the rationale for planning a discharge to that individual or agency; and

5. An assessment of the child's continuing needs, including, but not limited to, consideration of health care, behavior management and educational or vocational training.

(b) For discharges that were not anticipated at least 30 calendar days ahead of time, the facility shall send the Division's case manager or other placing agency a written plan at least 10 working days prior to the child's discharge. This plan shall specify the following information:

1. The date of admission;

2. Details of the events and circumstances leading to the discharge;

3. Efforts made to locate a runaway, if relevant;

4. An assessment of the child's continuing needs including, but not limited to, health care, behavior management and educational and vocational training; and

5. Recommendations for providing follow-up services in the child's new environment.

(c) For emergency discharges that result in the immediate placement of the child in a facility such as a detention center, hospital, psychiatric facility or any other placement outside the facility, the facility shall notify the Division's case manager or other placing agency by the next working day by telephone. The facility shall send a written discharge plan within 15 days after the child's discharge. This plan shall specify the information outlined in (b)1 through 5 above.

10:127-6.3 Grouping of children within living units

The facility shall determine the composition and size of children's groups within the living units on the basis of the children's treatment needs, gender, age and level of functioning.

10:127-6.4 Work and employment

(a) The facility shall not allow a child to be responsible for duties assigned to staff members.

(b) The facility may require children to perform work assignments in the facility that have an instructive value, including normal household chores, so long as these assignments are not scheduled to interfere with a child's school program, other aspects of the treatment or case management plan, or any regularly scheduled program activity for the children in the facility.

(c) The facility's staff members may encourage children to hold part-time employment outside the facility, but shall ensure that the work does not interfere with the child's school program, or other aspects of the treatment or case management plan.

1. The facility may require a child to maintain specific academic and behavioral standards as a condition for seeking or maintaining employment.

2. The facility may prohibit a child's employment, if a child does not maintain appropriate academic or behavioral standards, or if the job is determined to be detrimental to his or her health, safety or well-being.

10:127-6.5 Money and allowance

(a) The facility shall provide opportunities for all children to receive an allowance or to earn an allowance up to an amount as specified in their placement contract.

(b) The facility shall not require a child to assume responsibility for expenses for his or her care and treatment, except for amounts needed to pay for damage done to the facility by the child.

1. When a child damages the building or the facility's property, the facility shall identify the child who damaged the building or property in an incident report before requiring the child to pay restitution.

2. The restitution payments shall not exceed 30 percent of a child's weekly income from allowance.

3. Children who are working or have savings shall have the option to make a lump sum payment for intentional damages, if deemed clinically appropriate and consistent with the child's treatment plan.

4. The facility may offer the child the option of performing additional chores in lieu of restitution payments.

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10:127-6.6 Visitation and communication

(a) The treatment team shall determine the family members and friends with whom the child may communicate and visit.

1. The treatment team shall identify visitors with whom the child may have contact at intake and may revise the list at subsequent treatment planning or case management meetings.

2. Between treatment planning or case management meetings, the facility may curtail a child's contact with individuals after consultation with the Division or other placing agency if the facility:

i. Informs the child of the conditions of and reasons for restriction or termination; and

ii. Documents in the child's record the reasons for curtailing contact with the specified individuals.

(b) The facility shall develop a visiting policy and explain the visiting policy to the child and parents at intake. The visiting policy shall specify:

1. The hours for visiting family members and how alternative hours may be arranged;

2. That family visits shall not be denied for a child's infraction of rules, but may be denied if such visits would be contrary to the child's treatment plan;

3. That visitors who appear to be under the influence of drugs or alcohol shall not be allowed to visit or to transport the child;

4. That the child may visit his or her Division case manager or other placing agency worker upon reasonable request and that these visits shall not be unreasonably denied; and

5. The hours when a child may visit with friends and whether a child's visits with friends may be curtailed for a child's infraction of the rules.

(c) The facility shall *[adhere to]* ***meet*** the following ***requirements*** for the use of the telephone by children:

1. The facility shall permit reasonable access to a telephone by the child for telephone conversations with the Division's case managers or other professional persons ***or agencies*** *[involved in the child's treatment planning]*.

i. The child shall not be charged a cost for these telephone calls; and

ii. The facility shall provide adequate privacy for these telephone calls and all other calls but may locate the telephone in an area where a staff member can observe the child's reactions;

2. The facility shall permit reasonable access to the telephone by the child for telephone conversations with his or her parents. The facility may impose restrictions on these conversations if the following conditions exist:

i. The cost of the telephone calls is prohibitive; or

ii. The facility is complying with a court order which limits the child's contact with his or her parents;

3. When the facility imposes restrictions on a child's access to telephone conversations with his or her parents, as specified in (c)2 above, the facility shall:

i. Explain the nature of any restrictions to the child; and

ii. Document the rationale for imposing restrictions in the child's record;

4. The facility shall develop and maintain on file a written policy governing the use of the telephone by children when they communicate with friends. The facility may impose one or more of the following conditions:

i. Restricting the time and duration of telephone calls;

ii. Requiring the child to pay for telephone calls with friends;

iii. Denying the child use of the telephone for infraction of house rules; and

iv. Requesting the child to identify telephone callers; and

5. The facility shall not use tapes or any other mechanical listening devices to monitor a child's telephone calls.

(d) The facility shall not restrict the amount of mail a child sends or receives, unless a court order stipulates such restriction.

1. The child shall receive a postage allowance and writing materials for corresponding with family, friends and other persons who have a positive impact on the child's treatment.

2. No staff member shall open the child's parcels or letters or read the child's letters unless the child is physically incapable of doing so, and then only in the presence of both the child and another staff member.

3. A staff member may ask a child to open parcels and letters in the staff member's presence along with at least one other staff member only if he or she suspects the contents to be contraband, as specified in N.J.A.C. 10:127-6.15.

i. If the child refuses to comply with the staff member's request, the facility shall store the parcel or letter in a secure place until the child complies or is discharged.

ii. The facility shall document the rationale for and the outcome of all incidents when a staff member asks a child to open mail in a staff member's presence.

10:127-6.7 Education

(a) Facilities located in New Jersey shall ensure that school-age children receive educational instruction to which they are entitled under provisions of Federal and State education laws and regulations.

(b) Facilities located in other states shall ensure that school-age children receive educational instruction to which they are entitled under provisions of education laws and regulations of the state in which they are located.

(c) Education shall be provided either in a public school or private educational institution in the community or in an approved on-grounds school operated by the facility.

(d) The facility shall ensure that any child who is legally not attending school is either gainfully employed or enrolled in a training program that teaches necessary life skills or methods of job acquisition.

(e) The facility shall provide or utilize on-grounds or community vocational education services appropriate to the age, skill level, interests and abilities of those children who require such services.

(f) Requirements for facilities operating on-grounds education programs are as follows:

1. The facility shall provide an education program that ensures instruction is given to each school-age child in all specific curriculum areas identified in the Individualized Education Plan, as required by Federal education law, or in the child's treatment plan; and

2. The facility shall inform the child's appropriate school district if its on-grounds education program cannot provide instruction in all specific curriculum areas, as specified in (f)1 above.

(g) Requirements for facilities using off-grounds education programs are as follows:

1. When the facility determines that the child is ready to attend a public or community school, the facility shall make efforts to place the child in that setting and document such efforts in the child's record; and

2. When a child attends school in the community, the facility shall maintain regular contact with the teachers and other appropriate personnel concerning the child's progress.

(h) Requirements for facilities providing vocational programs are as follows:

1. A facility providing a vocational program shall ensure that the vocational services for a child include the following information:

i. Vocational evaluation;

ii. Formulation of vocational goals;

iii. Development of a vocational training plan; and

iv. Provision of skills training, employment counseling, job development and placement services or referral to appropriate sources providing these services.

(i) A facility with an on-grounds education program(s) shall maintain on file copies of all approvals and accreditations of its program and physical facilities from the department of education of the state in which it is located.

(j) The child's education record shall include:

1. Information used in the identification, classification and instruction of the child prior to developing a course of study or training to meet the child's academic or vocational needs, including records from the school district of residence and from previously attended residential facilities;

2. Initial and revised Individualized Education Plans, when legally required for the child;

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3. Results of educational testing and evaluations of the child;
4. Reports of the child's academic functioning, completed at regular intervals;
5. A vocational training plan for the child; and
6. If the child attends school in the community, quarterly academic progress reports obtained from the community school.

10:127-6.8 Recreation

(a) The facility shall plan or provide a balanced on-grounds and off-grounds recreation program. The recreation program shall include planned individual and group activities.

(b) The facility shall have a written schedule of daily planned recreational and leisure time activities.

1. The facility shall ensure that this schedule is developed with input from staff members and children.
2. The facility shall keep these schedules on file for 90 calendar days.

10:127-6.9 Religion

(a) If a facility's program has a particular religious orientation, the facility shall maintain on file in the facility a written description of its religious orientation and any religious practices or restrictions that are observed. Before the child's admission, the facility shall give this description to the child and the parents and discuss its religious orientation, if any.

(b) The facility shall ensure that each child is afforded the opportunity to participate freely in religious activities and/or services in accordance with his or her own faith or with that of his or her parents.

(c) The facility shall ensure that each child is permitted to attend religious activities and services ***provided either*** in the community ***or on site,*** and the facility shall arrange for or directly provide transportation***, if necessary,*** for any child who wishes to attend religious activities or services *[when]* ***unless*** deemed clinically *[appropriate]* ***inappropriate***.

(d) The facility shall not coerce or require children to participate in religious activities.

1. The facility shall not punish children who choose not to participate in religious activities.
2. The facility shall not give special rewards to children for participating in religious activities.

10:127-6.10 Rest, bedroom and sleep

(a) The facility shall ensure that:

1. Each child is provided with a standard household bed or crib, as age appropriate, in sanitary condition;
2. Each set of bunk beds:
i. Is limited to two in height;
ii. Has railings on the top bunk that are no more than 3½ inches from the top of the bed frame; and
iii. Has mattresses that are at least five inches from the top of the railing;
3. Each bed or crib is equipped with a firm, sanitary, fire retardant mattress and waterproof mattress cover;
4. Each child is provided with sanitary bed linens that are changed weekly, a blanket or other suitable covering that is cleaned or replaced, as necessary, and a pillow;
5. Two or more children do not share the same bed;
6. Children do not share the same bedroom with an adult, unless the adult is their mother and they are in placement in a facility that provides services to pregnant and parenting adolescents;
7. A child does not sleep on the same bed or crib that another child has occupied unless the bed linen is changed;
8. Children who are five years of age or older occupy a bedroom only with members of the same sex;
9. Each bedroom occupied by children has natural light and ventilation provided by one or more windows opening directly to the exterior;
10. An unfinished attic or basement is not used for sleeping purposes;
11. All rooms used as bedrooms are not used for any other purpose;
12. Each child is provided with a chest of drawers or some other permanent arrangement for storage of clothing and other personal belongings, including closet space or the equivalent;
13. Each child is permitted reasonable freedom to express his or her personal tastes in the decoration of his or her bedroom or bedroom area;
14. Each child has the opportunity for at least eight hours of uninterrupted sleep each night. Schedules for waking and retiring shall be adapted according to the ages, physical condition and characteristics of the children in each group;
15. The facility does not permit more than four children to occupy a designated bedroom space for sleeping. If partitions are used to designate a bedroom space, the facility shall ensure that the arrangement and height of partitions shall provide privacy for the occupants of the space;
16. Every bedroom is provided with a reading lamp or other means of artificial light for quiet activities; and
17. Every bedroom window is equipped with screens, curtains, blinds or shades.

10:127-6.11 Food and nutrition for children

(a) The facility shall ensure that each child is provided with three nutritious meals daily, either in the facility itself or in the community.

1. The facility shall make daily snacks available for children who desire them, unless there is a medical reason not to provide them.
2. The facility shall select, store, prepare and serve food in a sanitary and palatable manner.
3. The facility shall prepare and date menus and keep the menus on file at the facility for a minimum of 90 calendar days.
4. The facility shall provide place settings and eating utensils for children.
5. The facility shall serve meals in a manner that makes mealtime a pleasant social experience.
6. The facility shall not force-feed or otherwise coerce a child to eat, except by order of a physician.

(b) The facility shall ensure that the daily diet for each child includes a balance of foods from the four basic food groups.

1. The facility shall ensure that each meal contains a sufficient amount of food for each child.
2. The facility shall make available, as necessary, an alternate choice of food for each meal served for children on special diets or children who because of religious beliefs, cannot eat particular foods.
3. The facility shall follow individualized diets and feeding schedules that are submitted to the facility by the child's physician or registered dietician.

10:127-6.12 Pets

(a) The facility shall ensure that pets kept by or located in the facility regardless of ownership, shall be:

1. Domesticated and non-aggressive;
2. Free from disease;
3. Vaccinated, if applicable, as prescribed by law or as recommended by a licensed veterinarian. The record of the vaccinations shall be maintained on file at the facility, along with the name and address of the licensed veterinarian providing care for the pet;
4. If sick, removed from the area occupied by children, until the pet has been examined by a licensed veterinarian;
5. Effectively controlled by leash, command or cage; and
6. Prohibited from toilet facilities for staff members and children.

(b) The facility shall ensure that animal waste is disposed of in a manner that prevents the material from becoming a community health or nuisance problem. Accepted methods include:

1. Burial;
2. Disposal in sealed plastic bags; and
3. Utilization of:
i. A municipally approved trash removal system; or
ii. A sewage system for feces.

(c) The facility shall ensure that all pet dishes, food and equipment used for pets are kept out of the facility's food preparation and food serving areas when food is being prepared or served.

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(d) If a pet poses a health hazard to children, the facility shall take corrective action that is approved by the licensing agency.

(e) The facility shall ensure that pregnant adolescents are not permitted to clean a cat's litter box.

10:127-6.13 Restrictive behavior management practices

(a) Facilities that choose to utilize restrictive behavior management practices shall develop policies and procedures that assist children in gaining control of their behavior, protect the children from self-harm, protect other children or staff members, and prevent the destruction of property.

(b) The facility shall:

1. Obtain written approval from the Bureau for any restrictive behavior management practice that the facility plans to utilize prior to its implementation with children; and

2. Not utilize restrictive behavior management practices as a means of punishment, for the convenience of staff members, or as a substitute for a treatment program.

(c) Prior to the child's admission, the facility shall:

1. Explain to the parents, the child, and the Division's case manager or other placing agency any restrictive behavior management practice that is used, the circumstances under which it will be employed, and the possible risks involved; and

2. Obtain written consent for the use of all types of restrictive behavior management practices the facility uses from the child's parents.

(d) The facility shall ensure that the consent form is written in plain language and that either a translated version or an interpreter is available to explain it to non-English speaking or hearing impaired parents.

(e) Whenever the parents refuse to consent to a restrictive behavior management practice, revoke their consent for the practice, or cannot be located to give consent, the facility shall:

1. Refrain from utilizing the practice unless the child presents an imminent danger to self or others, and apply other, non-restrictive interventions until such consent is obtained; and

2. Request that the Division's case manager and the placing agency obtain the necessary consent, either through administrative action pursuant to an agreement between the parent, the Division and the other placing agency or through legal action, if necessary to protect the best interests of the child.

(f) The facility shall maintain a copy of all signed consent forms in the child's records.

(g) At least 10 working days before each staffing or treatment planning meeting, the facility shall send a letter to the child's parents and to the Division's case manager and other placing agency, which shall:

1. Inform them of the frequency and duration of any restrictive behavior management practice that was used with the child;

2. Describe how the child responded to the restrictive behavior management practice; and

3. Invite them to the treatment planning meeting to discuss the child's program and treatment status. If they do not attend the treatment plan meeting, the facility shall send the parents a written summary of the treatment plan meeting and a copy of the child's treatment plan.

(h) The facility shall develop and maintain on file in the administrative office a policy indicating which restrictive behavior management practices the facility uses.

(i) Facilities that utilize physical restraint with children shall:

1. Ensure that physical restraint is used only to protect a child from self-harm, or to protect other children or staff members, or to prevent the destruction of property when the child fails to respond to non-restrictive behavior management interventions;

2. Ensure that staff members use only physical restraint techniques and holds, such as the basket hold or restraining the child in the prone position. These techniques and holds shall not be utilized if the child has:

i. Not received a medical examination that specifically documents that he or she will not be adversely affected; or

ii. A documented respiratory ailment such as asthma, unless the physician authorizes such techniques;

3. Ensure that a child is released from restraint as soon as he or she has gained control;

4. Document each physical restraint incident in an incident report that reflects the following:

i. The name of the child;

ii. Date and time of day the restraint occurred;

iii. Name of all staff members involved in the restraint;

iv. Precipitating factors that led to the restraint;

v. Other non-restraint interventions attempted;

vi. Time the restraint ended;

vii. Condition of the child upon release; and

viii. Medical review by the nurse or physician if injury to the child is suspected;

5. Ensure that all restraint incidents are:

i. Reviewed by a supervisory staff member within one working day after the incident; and

ii. Discussed with the staff member involved in the restraint when the restraint is deemed improper within one working day after the incident;

6. Ensure that staff members who are involved in the restraint of a child receive training in safe techniques for physical restraint; and

7. Prohibit staff members from utilizing the following practices during a physical restraint:

i. Pulling a child's hair;

ii. Pinching a child's skin;

iii. Twisting a child's arm or leg in such a manner that would cause the child pain;

iv. Kneeling or sitting on the chest or back of a child;

v. Placing a choke hold on a child;

vi. Bending back a child's fingers;

vii. Intentionally shoving a child into walls and objects; and

viii. Allowing other children to assist in the restraint.

(j) Facilities that utilize exclusion shall:

1. Inform staff members through written policy of the circumstances when exclusion may be utilized as a behavior management intervention, such as:

i. Disruptive behavior, including fighting, name calling and pushing;

ii. Increased agitation on the part of the child;

iii. Non-compliant behavior or failure to participate in the program; and

iv. Uncontrollable emotional outbursts such as crying, screaming and inappropriate laughter;

2. Ensure that the child being excluded is not engaging in suicidal behavior;

3. Prohibit more than one child from being excluded in a room or area at a time;

4. Ensure that at least one staff member is responsible to make visual contact with the child every 15 minutes and is within hearing distance of the child when the child is removed from the group;

5. Ensure that the facility does not utilize a closet, bathroom, unfinished basement, unfinished attic *[or]**,* locked room ***or other unapproved area*** when excluding a child from the group;

6. Ensure that the exclusion of a child from the other children does not exceed 30 minutes and a child is not excluded from the group for more than a total of two hours in a *[24 hour]* ***24-hour*** period, unless there are *[documented]* circumstances *[by a physician,]* ***documented*** in the child's treatment plan ***by a physician's written order*** *[requiring longer]* ***extending the*** exclusion time;

7. Document each exclusion of a child in an incident report that reflects the following:

i. The name of the child;

ii. Date and time of day the exclusion occurred;

iii. Name of all staff members observing the child;

iv. Precipitating factors that led to the exclusion;

v. Other interventions attempted;

vi. Time the exclusion ended; and

vii. Condition of the child upon release; and

8. Ensure that the child is reintroduced to the group in a sensitive and non-punitive manner as soon as he or she has gained control.

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(k) Facilities that utilize mechanical restraint, in addition to taking the precautions listed for physical restraint in (i)1 through 7 above, shall:

1. Ensure that only leather restraints and soft handcuffs are utilized;

2. Discuss with the facility's staff physician or consulting physician the appropriateness of utilizing mechanical restraints with the child and secure the physician's initial approval before utilizing such restraint for the child;

3. Document in the child's treatment plan or record that other less restrictive practices have been considered and attempted before mechanical restraint was applied;

4. Ensure that staff utilizing mechanical restraints have received training in the administration of these restraints;

5. Instruct staff in the policies/procedures regarding the mechanical restraint, including the obligation to secure approval for each implementation of a mechanical restraint from the administrator and/or staff physician or consulting physician prior to implementing a mechanical restraint. Such approval shall be:

i. Documented in writing through signature by the administrator and/or staff physician or consulting physician; and

ii. Filed in the child's case record;

6. Ensure that the child is protected and handled in a manner which avoids injury when applying mechanical restraint;

7. Ensure that no more than one child is mechanically restrained in the same room or area at the same time;

8. Ensure that a staff member(s) remains at arm's length of the child and maintains visual contact at all times during the restraint or maintains visual contact utilizing a Bureau-approved television monitoring system;

9. Ensure that staff check the child's arms and legs every 15 minutes to prevent circulation problems;

10. Ensure that the child has access to toilet facilities;

11. Ensure that the child has access to all scheduled meals during the period restraints are being used;

12. Limit the use of mechanical restraint to no more than two consecutive hours and no more than four hours in a 24-hour period unless approval from a physician is obtained. The facility may request approval from the physician to exceed the time frame limitations for mechanical restraint when it appears that a child needs additional time to gain control of his or her behavior. A written copy of the physician's order to extend the time a child is placed in mechanical restraints shall be filed in the child's case record;

13. Have the child checked by a nurse or physician immediately afterward to ensure that the child has not suffered an injury. If a nurse or physician is not on grounds, the administrator on duty or staff member in charge shall immediately:

i. Contact the facility's on-call medical staff or the consulting physician; or

ii. Arrange a medical examination at the local hospital or clinic;

14. Explore other treatment options for a child whenever mechanical restraint proves ineffective or accelerates destructive/self-injurious behavior, including, but not limited to:

i. One-to-one staff supervision;

ii. Psychotropic medication, provided it is approved and prescribed by a physician; and/or

iii. Psychiatric hospitalization; and

15. Prohibit the use of the following types of mechanical restraints:

i. Straight jackets;

ii. Leg irons;

iii. Papoose boards;

iv. Ropes;

v. Metal handcuffs;

vi. Body wraps;

vii. Body tubes;

viii. Teflon handcuffs;

ix. Blanketing; and

x. Four and five point restraint.

(l) A facility that is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as a psychiatric hospital or facility and has a current contract with the Division may use four and five point restraint with a child. When the facility uses four or five point restraint, the facility shall comply with all the requirements for physical and mechanical restraint, with the exception of (k)15x above.

(m) A facility utilizing a behavior management room shall:

1. Ensure that the room:

i. Is unlocked at all times during its use;

ii. Is used for only one child at a time;

iii. Has floor space that provides a minimum of 70 square feet;

iv. Has a ceiling height of at least seven feet and six inches;

v. Has durable padded covering secured on the walls at least up to the six-foot level. The covering shall be made of a material that is fire retardant;

vi. Provides a minimum of 10 foot-candles of light in all areas of the room. All lighting fixtures shall have a protective covering to prevent tampering by a child;

vii. Has a door that is padded and equipped with a safety glass window to provide visibility of the room; and

viii. Has adequate ventilation that complies with local and state regulations;

2. Establish a written policy regarding the use of the behavior management room for children. This written policy shall specify:

i. Criteria for the use of this room, including those types of behavior that could result in the child's isolation;

ii. Those staff members who are authorized to place a child in the room;

iii. Procedures for ensuring the child's safety while confined in the room;

iv. Procedures for helping the child re-enter the group; and

v. Time frames governing a child's isolation in the room;

3. Ensure that no child remains in such a room for more than two consecutive hours or for more than four hours in a 24-hour period unless approval from a physician is obtained. The facility may request approval from the physician to exceed the time frame limitations for the use of the behavior management room when it appears that a child needs additional time to gain control of his or her behavior. A written copy of the physician's order to extend the time a child remains in the behavior management room shall be filed in the child's case record;

4. Ensure that objects such as belts, matches, pens or other potentially harmful objects are removed from the child prior to the child's placement in the behavior management room;

5. Ensure that there is no minimum length of time for placement when children are isolated in such a room;

6. Ensure that a staff member:

i. Maintains constant visual contact with any child considered to be at high risk if left unattended in such a room; and

ii. Visually observes a child not considered a high risk in such a room at least every 15 minutes to ensure the safety of the child;

7. Ensure that the child has access to toilet facilities;

8. Prohibit the use of a behavior management room for non-violent or non-assaultive offenses or behaviors or for practices to:

i. Prevent runaways;

ii. Seclude a child who is ill;

iii. Punish a child for stealing, cursing, or failing to cooperate with house rules;

iv. Facilitate supervision for the convenience of staff; and/or

v. Permit a child to eat his or her meals in such a room;

9. Maintain a log book detailing each use of the behavior management room. This log book shall contain the following:

i. The name of the child;

ii. The date and time of day that the child was placed in such a room;

iii. The signature of the supervising staff member authorizing placement;

iv. A description of the behavior precipitating the decision to place the child in such a room;

v. The time(s) the observing staff member checked on the child in such a room, including a description of the child's behavior and signature of the staff member responsible for observing the child;

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vi. The time that the child was removed from such a room;

vii. The child's condition and appearance at the time of removal; and

viii. The child's behavior upon return to the group; and

10. Maintain a copy of the log book entry as identified in (m)9 above in the child's record.

(n) Facilities that are operated by the Division shall adhere to all the restrictive behavior management practices policies that are developed, implemented and promulgated by the Department and the Division.

10:127-6.14 Discipline and control

(a) The facility shall develop house rules to help the children develop self-control and conform to acceptable patterns of social behavior.

1. The facility shall put the house rules in writing.

2. The house rules shall include a rationale for such rules and delineate the consequences for infractions.

3. The facility shall explain its disciplinary practices individually with each child at the time the child is placed in the facility.

4. The rules shall be maintained on file in the facility and made available to parents*[, as specified in N.J.A.C. 10:127-3.3]*.

5. The house rules may be incorporated in the child's bill of rights, as specified in N.J.A.C. 10:127-3.2.

(b) The facility shall assign responsibility for the discipline, control, and supervision of children to staff members and shall not delegate that responsibility to other children.

(c) The facility shall not threaten discipline or administer discipline to a child for the misbehavior of another child or group of children.

(d) The facility shall prohibit the following types of punishment from being used on a child:

1. Any type or threat of physical hitting or the use of corporal punishment;

2. Forced physical exercise or forcing a child to take an uncomfortable position;

3. Subjection to verbal abuse, ridicule, humiliation, or other forms of degradation;

4. Deprivation of meals, sleep, mail, clothing appropriate to the season or time of day, or verbal communication;

5. Mechanical or chemical restraint;

6. Assignment of overly strenuous physical work;

7. Exclusion from any essential program or treatment service, such as education or clinical treatment;

8. Refusal of entry to the residence;

9. Temporary suspension and return of a child from the facility to a parent, relative, foster home, or shelter, unless approved by the Division or other placing agency; and

10. Seclusion in a locked room.

10:127-6.15 Search and seizure of weapons and contraband; substance abuse screenings

(a) Facilities may conduct searches for weapons or contraband, provided that they maintain on file in the facility written policies and procedures that are consistent with the requirements of this chapter.

1. The facility shall define contraband to include illegal drugs, unauthorized property, stolen property or items otherwise obtained illegally.

2. The facility shall post the policy in an area conspicuous to children, explain the policy and distribute copies of the written policy to children and their parents upon admission and when changes are made to the policy.

3. The facility shall specify the actions that it will take when weapons or contraband are found.

(b) The facility shall prohibit all staff members, consultants and volunteers from strip searching a child for any reason.

(c) The facility shall permit frisk searches (surface searches of outer clothing) of a child only when there is reasonable suspicion that the child is in possession of a weapon.

1. The facility shall prohibit staff members from reaching into a child's pockets unless the frisk search confirms the reasonable belief that the child is in possession of a weapon.

2. The facility shall not frisk search a child who is suspected of possessing illegal drugs or contraband other than a weapon.

3. The facility shall ensure that a frisk search is conducted:

i. In the presence of two staff members, one of whom has supervisory or administrative responsibilities in the facility; and

ii. Only by staff members of the same sex as the child. If same sex staff members are not available, staff members shall provide one-to-one supervision of the child, until the search can be properly conducted.

(d) When the facility has reasonable suspicion that a child is carrying illegal drugs or other contraband in a garment, pocket, purse, or other possession within the child's immediate control, the facility shall ensure that the staff member:

1. Asks the child *[voluntarily]* to empty ***voluntarily*** any garment, pocket, purse or other possession;

2. Inspects all such items that are in plain view; and

3. If necessary, summons a law enforcement officer to conduct a lawful search of the possessions within the child's immediate control whenever the child refuses a voluntary search by the facility staff member.

(e) *[The facility may conduct periodic, unannounced searches of a child's room and other possessions not within a child's immediate possession or control if:]* ***If a facility has reasonable suspicion that a child's room or other possessions not within a child's immediate possession or control contain contraband, stolen property or weapons, the facility may conduct an unannounced search if:***

1. The facility has explained and documented this practice to the child and his or her parents, as specified in N.J.A.C. 10:127-3.2 and 3.6;

2. The search is conducted in the presence of two staff members, one of whom has supervisory or administrative responsibility; and

3. The facility allows the child an opportunity to be present during a search. If the child declines the opportunity, the staff members may conduct the search in the child's absence.

(f) When unannounced room searches occur, as specified in (e) above, the facility shall verify which child is responsible for any weapon or contraband brought into the facility before imposing a disciplinary action or sanction on the child.

(g) Before a facility conducts a blood or urine screening on a child to determine substance abuse, the facility shall ensure that:

1. Substance abuse screenings are conducted only under the following limited circumstances:

i. When screening is ordered by the court;

ii. When the facility is specifically designated as a drug treatment facility; or

iii. When ordered by a physician who has determined that such screening is necessary ***through review of the child's previous case history and current behavior***; and

2. Substance abuse screenings are conducted only if:

i. The facility has informed the child and parents, if available, beforehand about the screening;

ii. The facility uses a licensed facility to conduct the screening, including drawing the sample and completing the analysis;

iii. The facility ensures that the child has privacy when a urine sample is collected, unless the facility documents that the child has a history of falsifying samples. If the child has such a history, the facility shall request appropriate trained staff of the same sex as the child to witness or verify that the child is not falsifying samples; and

iv. The facility verifies the accuracy of all positive tests through a second screening; and

3. Substance abuse screenings are discontinued whenever previous screenings result in three consecutive negative readings after the initial positive reading was documented, unless a court order requires continued screenings.

(h) The facility shall maintain on file an incident report for every instance involving a frisk search of a child, a staff member's request for a child to empty a possession within the child's immediate

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control, a room search resulting in the discovery of weapons, illegal drugs or other contraband, and a blood or urine screening.

10:127-6.16 Firearms and weapons

(a) The facility shall not maintain any firearm, chemical or other weapon within or on the grounds of the facility.

(b) The facility shall prohibit any staff member or child to possess any firearm, chemical or other weapon within or on the grounds of the facility.

10:127-6.17 Aversive *[condition]* ***conditioning*** procedures

*[Any]* ***A*** facility that utilizes aversive conditioning procedures with developmentally disabled children shall first obtain written approval from the Bureau prior to *[its]* ***their*** implementation with children.

SUBCHAPTER 7. HEALTH REQUIREMENTS

10:127-7.1 Comprehensive health plan for children

(a) The facility shall prepare and implement a comprehensive health plan to ensure that each child's medical, dental, and other health needs are met adequately and promptly.

1. The facility shall identify a physician or health care organization who will assume responsibility for routine medical care of each child.

2. The facility shall arrange for emergency, routine and follow-up medical care for each child.

10:127-7.2 Health care and medical treatment for children

(a) Within 72 hours after admission, the facility shall ensure that each child receives a medical examination, as defined in (d) below, unless the child had received such a medical examination within 30 calendar days prior to his or her placement.

(b) When the facility suspects that a child is ill or carrying a contagious disease, the child shall be examined by a physician prior to admission.

(c) When the facility suspects that a child has been abused or neglected, the facility shall ensure that the child is examined by a physician immediately upon admission.

(d) The facility shall ensure that each child receives an annual comprehensive physical examination and shall maintain a copy of the results of this physical examination in the child's record.

1. The physical examination shall include, but not be limited to:

i. A measurement of height and weight;

ii. A determination of blood pressure;

iii. An objective vision screening which uses a Titmus or Snellen test, or equivalent;

iv. A hearing screening using an audiometer and, if indicated, tympanometry;

v. A hematocrit or Hemoglobin test, if indicated; and

vi. A urinalysis, if indicated.

2. The facility may use vision and hearing screening tests completed at the child's school if these tests meet the requirements specified in (d)1iii and iv above.

3. The facility shall ensure that eye glasses, orthopedic apparatus or other equipment are available to each child who requires them.

4. The facility shall ensure that all children 13 years of age and under receive a Mantoux tuberculin skin test unless they have had tuberculosis, and ensure follow-up with the physician if test results are positive.

5. The facility shall ensure that all children are appropriately immunized.

(e) The facility shall ensure that each child receives a dental examination within three months following admission and at least semi-annually thereafter.

(f) The facility shall ensure that children between two and six years of age receive developmental evaluations by a physician, nurse or other appropriate health official.

10:127-7.3 General medical practices

(a) The facility shall ensure that any medical, dental, psychological or psychiatric treatment or medication administered to a child is explained to the child.

(b) When a serious accident or illness occurs to a child, the facility shall take the necessary emergency action and notify the child's parents and the Division's case manager or other placing agency immediately. The facility shall document these incidents in the child's record.

(c) When a child or staff member has a communicable disease, as specified in the table in (c)3 below, the facility shall:

1. Obtain a written statement from a licensed physician treating the child or staff member, confirming the diagnosis and indicating that there is no risk to the child or staff member, or to others before the child or staff member participates in group activities;

2. Isolate the child or staff member posing a risk to others; and

3. Contact the New Jersey State Department of Health, the local health department or other appropriate public health authority when the child or staff member has a reportable disease, as specified in the table below.

TABLE OF COMMUNICABLE DISEASES

| Respiratory illnesses | Gastro-intestinal illnesses | Contact illnesses |
|---|---|---|
| Chicken pox | Giardia lamblia* | Impetigo |
| German measles* | Hepatitis A* | Lice |
| Hemophilus influenzae* | Salmonella* | Scabies |
| Measles* | Shigella* | |
| Meningococcus* | | |
| Mumps* | | |
| Strep throat | | |
| Tuberculosis* | | |
| Whooping cough* | | |

**[Reporting]* ***Reportable*** diseases, as specified in N.J.A.C. 10:127-7.3(c)3.

10:127-7.4 Medication other than psychotropic medication

(a) The facility shall administer prescription medication to a child only when the medication is authorized by a physician.

(b) The facility shall limit the dispensing of non-prescription over-the-counter medication to the following types, which shall be dispensed in accordance with the recommended dosage, age or weight of the child, as indicated on the label:

1. Antihistamines or decongestants;

2. Acetaminophens (or other age-approved aspirin substitutes);

3. Cough suppressants; and

4. Topical ointments.

(c) The facility may permit the dispensing of non-prescription medication other than those listed in (b) above if the child's physician authorizes it in writing.

(d) The facility shall maintain a medication log book that contains the following information:

1. The name of the child receiving medication, whether prescription or non-prescription;

2. The type of medication, dosage, and intervals between dosages;

3. What to do if a dosage is missed;

4. The reason for the medication;

5. The date and time the medication was administered;

6. Possible side effects of the medication, if any; and

7. The signature and title of the staff member dispensing the medication.

(e) The facility shall encourage the self-administration of medication by properly trained and supervised children whenever their intellectual, emotional and physical capabilities make such practice appropriate and feasible. This shall be documented in each child's treatment plan.

(f) The facility shall ensure that the following procedures for storage of medication are followed:

1. The facility shall keep all prescription and non-prescription medication in a locked cabinet or container, or, as needed, in a locked box in a refrigerator. The facility shall ensure that the keys to the locked cabinets, containers and locked boxes are adequately safeguarded and maintained by staff members and are kept out of reach of children;

2. All outdated stocks and prescriptions no longer in use shall be disposed of safely as follows:

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i. Liquid medication shall be poured down the drain, the bottles rinsed out and then disposed of in the trash; and

ii. Pills, tablets and capsules shall be flushed down the toilet before the bottle or packet is disposed of in the trash;

3. The telephone number of the regional poison control center shall be posted at all medication-dispensing stations and by each telephone; and

4. Staff members shall have access to medical supplies at all times.

(g) In situations where the facility determines that an adolescent is capable of self-administration of prescription birth control-related supplies, the facility may allow the adolescent to maintain such supplies amongst her personal possessions, so long as the facility:

1. Provides a locked cabinet or box for storage; and

2. Documents in the treatment plan the rationale and arrangements for the adolescent to maintain prescription birth control-related supplies.

10:127-7.5 Psychotropic medication

(a) The facility shall not administer medication to children as a punishment, for the convenience of staff members or as a substitute for a treatment program.

(b) The facility shall ensure that a pre-treatment clinical assessment, based on behaviors exhibited by the child and observed by staff members, is conducted by a licensed physician before psychotropic medication is prescribed. This pre-treatment clinical assessment shall include at least the following information:

1. A comprehensive drug history, including consideration of the use of all prescription and non-prescription drugs by the child as well as a history of cardiac, liver, renal, central nervous system or other diseases, a history of drug allergies and dietary information;

2. A laboratory work-up, including, but not limited to:

i. A complete blood count. If the medication prescribed requires routine follow-up blood work, this blood count test shall be administered prior to the child's beginning his or her medication regimen. If the medication prescribed does not require routine follow-up blood work, a new blood count test is not required as long as the child has had a blood count test within one year of admission, unless the physician determines otherwise;

ii. Urinalysis;

iii. Blood screening to include an assessment of liver and renal functions, if indicated; and

iv. Cardiogram (EKG) and electroencephalogram (EEG), as indicated, on children with previous histories of cardiac abnormalities or central nervous system disorders; and

3. A written description of:

i. Non-pharmacological interventions that were considered or attempted to address the child's behavior;

ii. The purpose of the medication, the specific behavior(s) of the child to be modified and ways in which progress towards the treatment objectives will be measured;

iii. The dosage; and

iv. How possible side effects will be monitored and reported to the physician who prescribed the medication.

(c) Within two weeks after admission, the facility shall ensure that all children already receiving psychotropic medication receive a clinical assessment by a physician, as specified in (b) above.

(d) The facility shall not be obligated to comply with (b) above and (e) below, for a pre-treatment clinical assessment and informed consent for psychotropic medication, other than long-acting drugs, if the treating physician certifies in the child's clinical record that the child presents a danger to self and/or others.

1. The initial decision to administer emergency medication shall be based on a personal examination of the child by a physician.

2. The initial administration of emergency medication may extend for a maximum period of 72 hours.

3. A physician may authorize the administration of medication for an additional 72 hours upon determination that the continuance of medication on an emergency basis is clinically necessary. This authorization may be given by telephone, provided that it is countersigned by the physician and certified as to the necessity in the child's clinical record within 24 hours. If this medication is then deemed necessary for the child's treatment while in the facility, the physician shall complete the pre-treatment clinical assessment as specified in (b) above.

4. The facility's staff members shall document on a separate reporting form that the psychotropic medication was administered in an emergency situation. The documentation shall identify possible side effects to be monitored as described in (b)3iv above.

(e) Before administering psychotropic medication, the facility shall obtain written informed consent from the child's parent(s) or legal guardian, and from all children 14 years of age and older consistent with their age and level of functioning unless the facility documents that the child lacks the capacity for informed consent. In cases where both a parent and legal guardian exist, the facility shall seek written informed consent from the legal guardian.

1. A physician, registered nurse or staff member trained in administering psychotropic medication shall obtain written informed consent.

2. The person requesting written informed consent shall ensure that parents, guardians and children are informed about:

i. The behavior or symptoms which the medication is intended to modify;

ii. The dosage;

iii. Any change in type of medication; and

iv. How possible side effects of the medication will be treated.

3. When a request for written informed consent is made by a staff member, the staff member shall inform the parent that a physician is available for consultation regarding the proposed medication.

4. The facility may obtain verbal informed consent by telephone from the child's parents when the facility, physician, registered nurse or staff member is unable to obtain written informed consent, provided that:

i. The facility documents the telephone call in the child's record; and

ii. The facility obtains the written informed consent from the child's parents or legal guardian within 24 hours of receiving the verbal informed consent.

5. If the facility cannot obtain written informed consent or verbal informed consent, the facility shall use certified mail, return receipt requested, and shall send the request to the parent's or legal guardian's last known address at least 10 calendar days before the proposed date for the commencement of treatment. The written notice shall specify:

i. The proposed date for beginning of treatment; and

ii. That a failure to respond by the proposed date for the beginning of treatment shall empower the director, after consultation with the Division's case manager or other placing agency, to grant consent for the medication.

6. The facility shall document all methods for requesting written consent in the child's record.

(f) When a parent, legal guardian or child refuses or revokes consent for medication, the following procedures shall apply:

1. The treating physician or his or her designee shall speak to the child or the parent or both to respond to the concerns about the medication. This person shall explain the child's condition, the reasons for prescribing the medication, the benefits and risks of taking the medication, and the advantages and disadvantages of alternative courses of action;

2. If the child or parent continues to refuse or revoke consent to medication and the physician or his or her designee still believes that medication is a necessary part of the child's treatment plan:

i. The director of the facility shall advise the child and the parent that the matter will be discussed at a meeting with the child's treatment team and shall invite the child and parent to attend such meeting;

ii. The director of the facility may suggest that the child and parent discuss the matter with a person of their own choosing, such as a relative, attorney, physician, or mental health clinician;

iii. The treatment team shall meet to discuss the treating physician's recommendations and the response of the child or parent; and

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iv. The treatment team shall attempt to formulate a viable treatment plan that is acceptable to the child and parent;

3. If, after the treatment team meeting, the child or parent continues to refuse or revoke consent to medication and the treating physician still believes that medication is a necessary part of the child's treatment plan, the facility shall obtain an independent psychiatric review. The psychiatrist conducting this independent assessment shall review the child's clinical record, conduct a personal examination of the child, provide a written report for the child's treatment team, and, if the parent or child is refusing or has revoked consent to medication, speak with the parent or child, respectively; and

4. If the child or parent continues to refuse or revoke consent to medication, and the facility feels that the child cannot be adequately treated without the medication, the facility may initiate an emergency discharge, as specified in N.J.A.C. 10:127-6.2(b) and 10.5.

(g) The facility shall administer psychotropic drugs in the following manner:

1. Psychotropic medication shall be dispensed only by licensed pharmacists and prescriptions shall always be labeled to reflect the following information:

i. The name and address of the dispensing pharmacy;

ii. The full name of the pharmacist;

iii. The full name of the child;

iv. Instructions for use, including the dosage and frequency;

v. The prescription file number;

vi. The dispensing date;

vii. The prescribing physician's full name;

viii. The name and strength of the medication;

ix. The quantity dispensed; and

x. Any cautionary information appropriate to the particular medication;

2. The facility shall encourage the self-administration of medication by properly trained and supervised children whenever their intellectual, emotional, and physical capabilities make such practice appropriate and feasible. The child's capability for self-administration of psychotropic medication shall be documented in the child's treatment plan; and

3. The facility shall ensure that psychotropic medication is stored as specified in N.J.A.C. 10:127-7.4(f).

(h) The facility shall ensure that all children receiving psychotropic medication are monitored in the following manner:

1. Staff members directly involved with the child shall record daily progress towards treatment goals and objectives and observed side effects which are identified in the pre-treatment clinical assessment;

2. Staff members shall notify the prescribing physician immediately, when side effects are observed;

3. The facility shall ensure that:

i. The physician or his or her designee reviews the child's behavior, well-being and status towards treatment goals and objectives, side effects and reason for continuing the medication every 30 days;

ii. The review is documented in the child's medical record; and

iii. The facility informs the child, parents, legal guardian, the Division's case manager or other placing agency in writing about the outcome of a negative review.

(i) The facility shall ensure that each staff member involved in administering psychotropic medication receives the following training:

1. Indications for drug use; and

2. Therapeutic effects and side effects.

(j) The facility shall record all information about a child's psychotropic medication, as specified in N.J.A.C. 10:127-7.4(d), and the facility shall ensure that the child's medication record is available to the physician for review when additional medication is prescribed.

10:127-7.6 Health education and physical care for children

(a) The facility shall ensure that children receive training in personal care, hygiene and grooming habits.

1. The facility shall discuss the physiological changes experienced during adolescence with children in the facility.

2. The facility shall instruct children about sexually responsible behavior including how to protect themselves from pregnancy and sexually transmitted diseases including AIDS.

3. The facility shall instruct all children about the health ***and social*** consequences of smoking tobacco products, smokeless tobacco, alcohol and drug abuse.

(b) The facility shall ensure that children are provided with the following:

1. Individual towels and washcloths;

2. Soap and toilet paper; and

3. Hygiene supplies that are age appropriate for their needs, such as toothpaste, mouthwash, deodorant, ***shampoo,*** razors, shaving cream and feminine hygiene articles.

(c) For children unable to provide for their own personal care and hygiene, the facility shall bathe and groom them, and provide other personal hygiene services that are necessary to meet their needs.

(d) The facility may permit residents to maintain over-the-counter cosmetics, acne preparations and personal hygiene supplies among their personal possessions.

(e) The facility shall take measures to ensure that each child has an adequate personal supply of clean, well-fitting and attractive clothing ***and footwear*** appropriate to his or her age, gender, individual needs, community standards, and season.

1. The facility shall ensure that each child's clothing is kept clean and in good repair. The facility may require children 12 years of age and older to do their own laundry.

2. The facility shall not require children to wear any article of clothing that would explicitly identify them as a resident of the facility.

10:127-7.7 Health requirements for staff

(a) Before working for a facility each staff member who comes in contact with the children for the equivalent of eight hours a week or more shall submit a written statement from a licensed physician indicating that he or she is in good health and poses no health risk to persons at the facility. Such statement shall be based on a medical examination conducted within the six months immediately preceding such person's association with the facility.

(b) *[Within one year prior]* ***Prior*** to or upon beginning work or having contact with the children for the equivalent of at least eight hours a week at the facility, each staff member shall take a Mantoux tuberculin skin test with five TU (tuberculin units) of PPD tuberculin. If the staff member has had a previous positive Mantoux tuberculin skin test the staff member shall have a chest x-ray taken in lieu of the Mantoux tuberculin skin test. The staff member shall submit to the facility written documentation of the results of the test or x-ray.

1. If the Mantoux tuberculin skin test result is insignificant (zero to nine millimeters (mm) of induration), no further testing shall be required. The Bureau or facility may, at any time, require a staff member to retake the Mantoux tuberculin skin test, if there is a reason to believe or suspect that the staff member may have contracted tuberculosis or if the State Department of Health recommends retesting.

2. If the Mantoux tuberculin skin test result is significant (10 or more mm of induration), the individual shall have a chest x-ray taken. If the chest x-ray shows positive results, the facility shall require that the staff member obtain a written statement from a physician certifying that he or she poses no threat of tuberculosis contagion before allowing the staff member to come in contact with the children. The facility shall ensure that the staff member adheres to the recommended follow-up testing, if any, by the physician.

3. The facility shall prohibit any staff member who fails to submit satisfactory results from having contact with the children at the facility.

(c) The facility shall maintain on file the results of each staff member's:

1. Mantoux tuberculin skin test or chest x-ray when indicated; and

2. Physical examination.

(d) The facility shall exclude a staff member who appears to be physically, emotionally or mentally impaired or who appears to have

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a drug-induced or alcohol-induced condition that would endanger the health, safety and well-being of the children or other staff members. The facility shall document the action taken to exclude the staff member and maintain such documentation in the staff member's personnel record. The facility shall not permit the staff member to reassume duties until the condition is no longer present as specified in N.J.A.C. 10:127-5.1(a).

10:127-7.8 Environmental sanitation and staff hygiene

(a) Staff members shall use disposable rubber gloves, which shall be discarded after each use, when coming into contact with blood, vomit, urine, fecal matter or other body secretions.

(b) The facility shall ensure that areas in the facility, bedding, furniture, carpeting and clothing, that come into contact with blood, vomit, urine, fecal matter or other body secretions are disinfected with a commercially prepared disinfectant that indicates it kills bacteria, viruses and parasites. This solution shall be used in accordance with label instructions.

(c) The following equipment items or surfaces shall be washed and disinfected after an incident, as specified in (b) above:

1. Toilet seats;
2. Sinks and faucets;
3. Mops that were used in the clean-up;
4. Washcloths, towels and sponges that were used in the clean-up; and
5. Thermometers.

SUBCHAPTER 8. TRANSPORTATION REQUIREMENTS

10:127-8.1 General requirements

(a) The provisions of this subchapter shall apply to each facility that provides or arranges transportation for children:

1. To or from the facility or between other prearranged sites and the facility; or
2. In connection with an activity (such as a field trip) conducted by or under the auspices of the facility.

(b) Each facility as specified in (a) above shall also comply with applicable provisions of the New Jersey Division of Motor Vehicles law, pursuant to N.J.S.A. 39:1-1 et seq. and rules promulgated thereunder, as specified in N.J.A.C. 13.

(c) The facility may authorize staff members to utilize their own private passenger vehicles to transport children from the facility to and from scheduled field trips or to transport children from the facility to a hospital, clinic or office for medical treatment. However, staff members may be authorized to do so only if:

1. The vehicle has a capacity of eight or fewer persons;
2. The driver possesses a valid automobile driver's license issued by the New Jersey Division of Motor Vehicles, hereinafter referred to as the DMV, or a valid automobile driver's license issued by an approved out-of-State motor vehicle agency for the state in which the driver is a legal resident;
3. The vehicle has a valid motor vehicle inspection sticker issued by the DMV or by an approved out-of-State motor vehicle agency for the state in which the car is legally registered;
4. The vehicle owner possesses liability insurance at least at the minimum amounts required by the New Jersey State insurance law, pursuant to N.J.S.A. 17:28-1.1a or at least the minimum amounts required by a state other than New Jersey in which the car is legally registered;
5. The facility maintains transportation records on every vehicle utilized for the above, as specified in N.J.A.C. 10:127-8.4; and
6. The facility ensures that staff members apply the safety practices specified in (d) and (e) below.

(d) The facility shall ensure that all vehicles used to transport children:

1. Are maintained in clean and safe condition;

***2. Are free from tobacco smoke and the use of smokeless tobacco while children are passengers;***

*[2.]***3*** Have a maximum seating capacity that does not exceed the number of seat belts (unless the vehicle is not required by law to have seat belts);

*[3.]***4.*** Have seats and back rests securely fastened;

*[4.]***5.*** Have all seats that are facing sideways or backwards bolted down;

*[5.]***6.*** Have seats upholstered with springs or foam rubber;

*[6.]***7.*** Have an operable heater capable of maintaining a temperature of 50 degrees Fahrenheit; and

*[7.]***8.*** Are equipped with:

i. A triangular portable red reflector device;

ii. All season radial or snow tires from November 15 through April 1 (for New Jersey-based facilities only); and

iii. A removable, moisture-proof and dust-proof first-aid kit, which shall be located in the vehicle.

(e) The facility shall ensure that the following safety practices are followed:

1. A staff member is always present when an adolescent, child or infant is in the vehicle;
2. All passengers who are over one and one-half years of age are secured in a car seat or an operable seat belt while the vehicle is in motion;
3. All passengers who are one and one-half years of age or younger are secured in car seats (child passenger restraint systems) that meet Federal motor vehicle safety standards in accordance with provisions of the New Jersey Division of Motor Vehicles law, pursuant to N.J.S.A. 39:3-76.2a;
4. All adolescents, children and infants are loaded and unloaded from the curbside of the vehicle; and
5. Chidren are not permitted to ride in the back or beds of trucks.

(f) When transporting more than six children below six years of age, the facility shall ensure that one adult in addition to the driver remains in the vehicle.

(g) When transporting more than four infants without their adolescent mothers, the facility shall ensure that one adult in addition to the driver remains in the vehicle.

(h) The facility shall maintain transportation records, as specified in N.J.A.C. 10:127-8.4.

(i) If the facility utilizies a Type I School Bus, Type II School Bus or a Type II School Vehicle, the facility shall:

1. Meet all applicable rules of the DMV, New Jersey Department of Education and New Jersey Department of Human Services; and
2. Ensure that the drivers of such vehicles possess a valid Class B license for the New Jersey Type I School Bus, or possess a valid Class C license for the New Jersey Type II School Bus or an out-of-State equivalent license, as approved by the DMV.

(j) The facility shall limit travel for an adventure activity in program vehicles including cars, vans and wagon trains by:

1. Scheduling at least one full day of rest after every five days of travel;
2. Ensuring that no staff member drives for more than four hours without a 30-minute break; and
3. Prohibiting scheduled driving between 11:00 P.M. and 6:00 A.M., unless it is necessary to complete an emergency evacuation.

10:127-8.2 Vehicle insurance requirements

(a) The facility shall maintain vehicle liability insurance for bodily injury or death in minimum amounts of $300,000 per person and $500,000 per accident for every vehicle that is:

1. Owned or leased by the facility; and
2. Utilized to transport children residing in the facility.

(b) If the facility contracts for transportation services, the facility shall ensure that the contracted company maintains insurance coverage as identified in (a) above.

10:127-8.3 Additional requirements for transporting physically handicapped, non-ambulatory children

(a) Facilities providing or arranging for transportation services for physically handicapped children who are non-ambulatory shall have a vehicle that has a ramp device or hydraulic lift with a lift minimum pay load of 600 pounds. Any ramp device that is installed shall:

1. Have a non-skid surface;
2. Be securely stored and protected from the elements when not in use; and
3. Have at least three feet of length for each foot of incline.

(b) If wheelchairs are used, the facility shall ensure that:

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1. All wheelchairs are securely fastened and face forward;
2. All wheelchair passengers are secured with a seat belt;
3. Arrangements for wheelchairs do not impede access to emergency and exit doors; and
4. Any aisle leading from a wheelchair position to the emergency or exit door has a minimum width of 30 inches.

10:127-8.4 Record requirements

(a) The facility shall ensure that each person who is authorized to transport children possesses a valid driver's license.

(b) The facility shall maintain on file the following:

1. A photostatic copy of the registration of each vehicle used to transport children;
2. A copy of the insurance policy for every vehicle owned, leased, contracted or utilized by the facility; and
3. The name and address of the lessor or contractor furnishing a vehicle to the facility, if applicable.

(c) The facility shall maintain transportation maintenance records for all vehicles used by the facility for the transportation of children, including repair and inspection records, and shall retain them for the lifetime of the vehicles.

(d) The facility shall develop and maintain on file a record of all trips where the facility's vehicles are used for transporting children that documents:

1. The date and time each staff member drove;
2. Incidents of the day; and
3. Names of the children who attended the trip.

SUBCHAPTER 9. ADVENTURE ACTIVITIES

10:127-9.1 General requirements

(a) The requirements of this subchapter shall apply to any facility that provides or contracts for adventure activities that may include, but are not limited to:

1. Biking;
2. Canoeing, kayaking and tubing;
3. Caving;
4. Hiking;
5. Horseback riding;
6. Ropes initiatives and rock climbing;
7. Sailing and boating;
8. Snow skiing;
9. Solos;
10. Swimming;
11. Water skiing; and
12. Camping.

(b) All facilities whose program consists primarily of adventure activities shall maintain on file a written statement of purpose that shall identify the following:

1. The facility's philosophy, goals, and objectives;
2. Characteristics of the children to be served;
3. Types of adventure activities that a child may participate in and other treatment services provided to the children, including those provided directly by the facility and those services that may be provided in cooperation with community agencies or outside individuals;
4. Procedures for implementing those services; and
5. Criteria for successful completion of the program.

(c) For facilities whose program consists primarily of adventure activities, the facility shall describe to the child and the parents prior to admission to the facility, the types of adventure activities in which the child will be asked to participate. This discussion shall include:

1. An explanation of the anticipated benefits of the activity;
2. A description of the potential risks of the activity, as well as an explanation of how the facility will take precautions to minimize risks; and
3. A statement that the facility will not force or coerce a child to participate in any adventure activity, as specified in (i) below.

(d) For facilities whose program does not consist primarily of adventure activities, the facility shall discuss with the child and his or her parents the information specified above before the child is scheduled to participate in the activity.

(e) The facility shall document in the child's record that a staff member discussed the information specified in (c) and (d) above.

(f) The facility shall maintain on file at the facility's administrative office a list of all children and staff members who participate in an adventure activity that occurs away from the grounds of the facility.

(g) The facility shall have a fully-stocked first aid kit that is activity-appropriate and available whenever an activity occurs off-grounds.

(h) The facility shall ensure that all children and staff members receive instruction about the value of the activity and necessary safety precautions, such as how to prevent dehydration, frostbite, heat exhaustion, hyperthermia, hypothermia, poisoning from plants and animals, sun poisoning, snow blindness, or drowning.

(i) The facility shall not force or coerce a child to participate in any adventure activity, but may require a child to observe an adventure activity to assist the child in *[getting over]* ***overcoming*** his or her fears of a particular activity or to foster an interest in participating in a particular activity.

(j) The facility shall not engage in any activities requiring or involving firearms nor permit staff to have firearms.

(k) The facility shall prohibit airborne activities including*[, but not limited to,]* ***bungee jumping,*** hang gliding and parachuting.

(l) The facility shall not permit children to use power tools and lawn mowers unless the children wear protective safety glasses and work shoes or boots, and are under the direct supervision of staff members.

(m) The facility shall not allow children or staff members to participate in manufacturer's tests of new adventure equipment.

(n) For all water and outdoor trips away from the grounds or campsites, the facility shall obtain and maintain on file in the shift log or at the administrative office the information from a weather report issued by the National Weather Service no earlier than six hours before the trip and modify or cancel the activity if there is a threat of a severe storm or similar environmental hazard.

(o) The facility shall also obtain and maintain on file in the shift log or at the administrative office the information from a report from the park service or other appropriate state or local agency that indicates that there is no life-threatening environmental hazard, such as fires, polluted water, threat of flash floods or avalanches.

(p) The facility shall not engage in water activities where the water is known to have hazardous wastes, such as waters that have been contaminated by toxins, sewage or chemicals.

(q) The facility shall ensure that all water in streams, ponds, lakes and rivers that is used for drinking, food preparation and dishwashing is first boiled, filtered or purified with iodine or tablets specifically designed to purify water.

(r) The facility shall ensure that all children receive instruction in the use of personal floatation devices (life jackets) prior to their participation in water activities.

10:127-9.2 Plans for emergency evacuation and search and rescue

(a) The facility shall develop and maintain on file at the administrative office a written plan detailing procedures for emergency evacuation from any site used for adventure activities that is in a remote area or that is away from ordinary means of communication. This plan shall include, but not be limited to, the following:

1. Guidelines on how to determine dangerous weather conditions, such as storms, and life-threatening environmental hazards, such as fires, polluted waters, flash floods or avalanches;
2. Guidelines on how to determine whether a victim can walk out on his or her own power;
3. Guidelines for evacuating all children and staff members; and
4. Name, address and telephone number of local rescue squads, law enforcement agencies and hospitals, and guidelines for contacting them.

(b) The facility shall develop and maintain on file at the administrative office a written plan detailing procedures for search and rescue for each adventure activity that takes place outside the facility's grounds. This plan shall include, but not be limited to, the following:

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1. Guidelines on how to conduct a search to determine that a child is missing, including a time limit for ending the search and starting a search beyond the area being used for the adventure activity;
2. Procedures for completing a full description of the missing person;
3. Procedures detailing how to deploy staff and children to scout specific areas;
4. Procedures detailing how to deploy a rescue team that shall include a staff member to seek outside help;
5. A policy that indicates when to call law enforcement agencies and telephone numbers of local law enforcement officials; and
6. Procedures for reviewing the incident with the person(s) who conducted the search.

(c) For adventure activities occurring outside the facility's grounds, the facility shall ensure that each staff member supervising an adventure activity:
1. Reviews the plan detailing the procedures for emergency evacuation;
2. Reviews the plan detailing the procedures for search and rescue; and
3. Brings a copy of these plans on each adventure activity.

(d) The director of the facility or his or her designee shall document and maintain on file at the administrative office that all emergency evacuation and search and rescue missions were reviewed within five days of the incident, and issue a statement to staff members indicating approval or recommendations for improving these practices, if applicable.

(e) For adventure activities occurring outside the facility's grounds, the facility shall give at least one staff member money or credit cards to handle emergencies.

10:127-9.3 Reporting requirements

(a) The facility shall report all fatalities and all accidents requiring hospitalization or medical care by a physician to the Bureau as soon as staff have access to a telephone, as specified in N.J.A.C. 10:127-3.7(b).

(b) The facility shall provide written notification and maintain on file reports of all incidents and accidents requiring hospitalization or medical care by a physician, and incidents where an accident or fatality was avoided ("near miss"), within five working days of the incident.
1. This documentation shall specify:
i. The factors leading to the incident;
ii. The nature of the fatality, accident or "near miss";
iii. How staff members handled the incident; and
iv. Recommendations for avoiding such incidents in the future.
2. The director of the facility or his or her designee shall document in writing and maintain on file that he or she reviewed every incident and accident within five working days after the incident or accident occurred.
3. The facility shall send a written report within 10 working days of the incident or accident to the Bureau and to the child's parents about what precautions have been taken to prevent a similar kind of incident or accident from occurring in the future.

(c) The facility shall submit a written description to the Bureau and permit an on-site inspection prior to its implementation of any of the following high risk adventure activities:
1. Caving;
2. Ropes initiatives and rock climbing; and
3. Solo camping.

(d) The facility shall submit a written description to the Bureau prior to the implementation of the following medium risk adventure activities:
1. Canoeing, kayaking and tubing;
2. Water skiing;
3. Snow skiing; and
4. Boating and sailing.

(e) The written descriptions required in (c) and (d) above shall include, but not be limited to, the following information:
1. The types of equipment that will be utilized;
2. The qualifications of the staff members who will be involved in implementing the adventure activity; and
3. The policies and procedures to ensure the safety of the children and staff members during the adventure activity.

10:127-9.4 Biking

(a) Prior to implementing a planned biking trip that is off the grounds of the facility and that is more than *[five]* ***10*** miles in duration, the facility shall:
1. Obtain the necessary permits to ride on roads or highways from host states and local governments where applicable; and
2. Maintain on file at the administrative office copies of these permits.

(b) The facility shall prohibit all biking from taking place:
1. In inclement weather;
2. On roads with heavy traffic unless there is a wide shoulder;
3. After sunset and before sunrise; and
4. Off trails and in prohibited areas.

(c) The facility shall ensure that all persons engaged in biking:
1. Wear helmets that are approved by the American National Standards Institute (ANSI) or the Snell Memorial Fund;
2. Ride in a single file on the right side of the road;
3. Obey all traffic signs and signals;
4. Yield to traffic;
5. Are led by a staff member, *[with]* ***and for groups of four or more children have*** another staff member riding at the end of the group; and
6. Take a 30-minute break every two hours, or sooner when a child expresses a need for rest or when a child is injured or ill.

(d) The facility shall ensure that the following equipment is brought on a biking trip:
1. A road map;
2. A bike repair kit; and
3. A water bottle for each child and staff member, unless the itinerary provides access to potable water.

(e) The facility shall ensure that all bikes are locked at night to deter children from running away or having the bikes stolen.

(f) Before starting a trip and every day of the trip thereafter, the facility shall ensure that all bikes have:
1. Brakes that are in good working order;
2. Tires with treads and sufficient air;
3. Handle bars that are no more than 16 inches above the seat so that the biker can sit comfortably;
4. Pedals with treads that are a distance of 3½ inches or more from the front wheel or fender; and
5. Reflectors in the front, rear, pedals and spokes.

10:127-9.5 Canoeing, kayaking, and tubing

(a) The facility shall ensure that all children and those staff members who do not have a valid lifesaving or lifeguarding certificate:
1. Wear personal flotation devices (PFD) (life jackets) rated Class I, II, or III by the United States (U.S.) Coast Guard; and
2. Are instructed to never stand up in the canoe, kayak or tube, unless the children are in a confined area for staff supervised activities.

(b) The facility shall ensure that life jackets are not used for seating or bedding.

(c) The facility shall ensure that:
1. At least one staff member is present who has a valid lifesaving or lifeguarding certificate issued from an organization that is recognized by the New Jersey State Department of Health or other appropriate authority when there are eight or fewer children;
2. At least two staff members are present who have a valid lifesaving or lifeguarding certificate issued from an organization that is recognized by the New Jersey State Department of Health or other appropriate authority when there are nine or more children;
3. Children and staff members wear footwear that is secured to their feet, unless the activity occurs on a lake with a sandy bottom and no rocks; and
4. All children and staff members stay away from debris and any trees that have fallen across the river and carry the canoe, kayak

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or tube along the river bank past the debris or fallen tree, if necessary.

(d) The facility shall prohibit canoeing, kayaking, and tubing:

1. At night;

2. In the open ocean; and

3. During electrical storms.

(e) The facility shall ensure that the following equipment is brought along:

1. One spare life jacket for every 12 persons; and

2. Throw lines.

(f) For canoeing and kayaking, the facility shall ensure that:

1. Each canoe and kayak has flotation at either end;

2. *[Each canoe and kayak has]* ***For every three canoes or kayaks there is*** an extra paddle;

3. All equipment is secured;

4. Spray covers, if used, release promptly; and

5. The water temperature is 55 degrees Fahrenheit or higher unless a wet suit is provided to each child and staff member.

(g) For canoe or kayak trips in water with rapids rated Class III on the International Scale of River Difficulty (hereinafter referred to as the ISRD) developed by The American Canoe Association, the facility shall ensure that:

1. All children and staff members have completed at least three trips on water with rapids rated as Class I or II by the ISRD; and

2. All children and staff members wear helmets that are secured under the chin.

(h) The facility shall not take children on water with rapids rated Class IV or higher on the ISRD.

(i) For tubing, the facility shall prohibit trips when the water is:

1. Less than 55 degrees Fahrenheit; and/or

2. Rated above Class I on the ISRD.

10:127-9.6 Caving

(a) The facility shall ensure that:

1. No child or staff member who is known to be claustrophobic is taken on a caving trip;

2. All children and staff members wear helmets that are secured under the chin at all times;

3. At least three-quarters of the children on the caving trip are 12 years of age or older;

4. Children wear gloves if crawling is required;

5. Children have had at least two caving expeditions in horizontal caves before going into a vertical cave;

6. Children do not climb in vertical caves by hand-over-hand ropes methods;

7. Children and staff members do not run or jump in the cave;

8. All debris and human waste from children and staff members are carried out of the cave;

9. Animals and plants are left unharmed; and

10. No marking or vandalism is done within the cave by children or staff members.

(b) The facility shall ensure that at least one staff member on the trip:

1. Knows how to contact a local emergency rescue squad, such as the Cave Rescue Communications Network;

2. Is familiar with the terrain of the cave;

3. Carries a map of the cave, if available; and

4. Knows how to assist a child or staff member who becomes claustrophobic.

(c) For non-commercial caves, the facility shall obtain written permission to enter the cave from the owner or public authority and maintain this on file at the administrative office for two years from the date of the expedition.

(d) The facility shall ensure that the following equipment is brought along on all non-commercial caving expeditions:

1. A space blanket;

2. A whistle;

3. Three sources of light, one of which is either carbide, electric or a miner's headlamp;

4. Waterproof matches;

5. Potable water;

6. Climbing rope;

7. Emergency food;

8. Spare clothes; and

9. A first aid kit.

10:127-9.7 Hiking

(a) The requirements of this section shall apply to all walks or hiking expeditions in remote areas that are away from ordinary means of communication.

(b) The facility shall ensure that:

1. At least two staff members carry and know how to use a compass;

2. A first aid kit is brought along that includes treatment for snake, animal and insect bites, and treatment for contact with poisonous plants;

3. All children and staff members wear footwear appropriate for hiking;

4. No child or staff member carries a pack weighing more than 45 percent of his or her body weight; and

5. No child or staff member is allowed to destroy the environment.

(c) The facility shall ensure that each child and staff member has access to potable water.

10:127-9.8 Horseback riding

(a) The facility shall ensure that all staff members and children who go horseback riding wear ***long trousers and*** shoes or boots that have heels*[, long trousers, and]*. **In addition all children shall wear*** approved protective head gear that is secured under the chin.

(b) The facility shall ensure that:

1. The horse can be ridden and controlled by the rider according to his or her level of experience;

2. Two or more persons do not ride a horse at the same time;

3. The time a horse spends in ring riding is limited to a total of six hours a day, with no more than three hours of riding without at least a 15-minute break; and

4. The time a horse spends in trail riding is limited to a total of eight hours a day, with no more than four hours of riding without at least a 15-minute break.

(c) The facility shall ensure that horses it owns are:

1. Checked daily, including the mouth;

2. Checked daily for cracked feet and reshod as necessary;

3. Fed at least once a day or according to a specified feeding schedule; and

4. Given water at least once a day or according to a specified watering schedule.

(d) The facility shall retain on file at the barn housing the horses or at the administrative office documentation of compliance with the requirements specified in (c) above.

10:127-9.9 Ropes initiatives and rock climbing

(a) The facility shall ensure that staff members:

1. State the objectives of the ropes course or climbing trip to the children;

2. Emphasize the importance of safety procedures of each initiative to the children before starting the activity;

3. Allow each child to decide whether or not to participate in a ropes course;

4. Inspect the ropes before each group of children uses them; and

5. Demonstrate effective observation ("spotting") and how one is secured by a rope ("belayed").

(b) The facility shall prohibit:

1. Smoking near the ropes;

2. The wearing of jewelry, loose clothing and hair, and eyeglasses that are not secured that may be hazardous to participants or spotters;

3. Unsafe practices including, but not limited to, solo climbing, hanging upside down, throwing people or over-straining; and

4. The activity known as the "electric fence," in which a rope is attached to trees or poles and suspended four feet from the ground in a circle, and children standing inside the rope are expected to get out without touching the rope or passing under the rope.

(c) The facility shall ensure that persons on high ropes or rock climbing activities:

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1. Are individually secured with an approved rope, or "belayed"; and

2. Wear helmets that are fastened under the chin.

(d) The facility shall document and maintain on file at the site of the ropes course or at the administrative office that all belay ropes are:

1. Approved by the Union of International Alpine Association (UIAA);

2. Visually inspected by staff members before use and discarded if the rope appears frayed or damaged; and

3. *[Logged for use and retired at four years from the date of purchase or after the rope has sustained the number of falls that the manufacturer's label indicates that the rope can sustain. The facility shall develop and implement a system for measuring the rope's usable life.]* ***Incorporated into a system developed by the facility for measuring the rope's usable life. This system shall include a log for each rope as well as a standard (that is, logged for use and retired at four years from the date of purchase, or in a rock climbing element, retired after the rope has sustained the number of falls the manufacturer's label indicates the rope can sustain).***

(e) The facility shall ensure that all carbiners that are used to secure belay ropes are constructed of steel or a metal of equal strength and hardness, and have a locking gate.

10:127-9.10 Sailing and boating

(a) The facility shall ensure that all sailing vessels and motor boats used by children and staff comply with all applicable Federal, state and local laws.

(b) The facility shall develop and have on file at the administrative office a plan for each boating activity specifying:

1. A description of the boat and engine, if applicable;

2. The names of all persons aboard;

3. The survival equipment on board;

4. The itinerary ***and weather condition check***; and

5. The phone number of the closest Coast Guard station ***or National Park Service***.

(c) The facility shall ensure that at least one staff member has completed a boating course offered by the U.S. Coast Guard Auxiliary, U.S. Power Squad, American Red Cross, or the equivalent.

(d) The facility shall ensure that the following non-commercial boats have a current decal indicating a satisfactory rating on a courtesy inspection by the U.S. Coast Guard Auxiliary;

*[1. For motor boats, 12 feet to 65 feet; and

2. For sailboats, 16 feet to 65 feet.]*

***1. For class A—boats less than 16 feet;**

**2. For class 1—boats 16 feet and over but less than 26 feet;**

**3. For class 2—boats 26 feet and over but less than 40 feet; and**

**4. For class 3—boats 40 feet and over.***

(e) For sailboats and motor boats less than 16 feet, the facility shall ensure that there is a throw line and a personal flotation device (PFD) rated Class I, Class II or III by the U.S. Coast Guard on board for every passenger.

(f) The facility shall not take Division supervised children sailing and boating outside U.S. coastal waters, unless permission is obtained from the Division.

(g) The facility shall ensure that all marine heads (toilets) are certified by the U.S. Coast Guard of a type authorized for the area where the boating will occur.

***(h) The survival equipment on board shall be Coast Guard approved and shall include the following:**

**1. A personal flotation device (PFD) for each passenger as specified in (e) below;**

**2. Fire extinguishers of the proper type and size for the boat being used;**

**3. A whistle, bell, or horn;**

**4. Signal flares or distress lantern;**

**5. Anchor and line;**

**6. Oars/paddles;**

**7. Manual pump or hand bailer;**

**8. Navigation lights;**

**9. Mooring line;**

**10. Life rings;**

**11. Flashlights;**

**12. Drinking water and emergency food;**

**13. Tool kit;**

**14. Navigation charts; and**

**15. An appropriate size first aid kit.***

10:127-9.11 Snow skiing

(a) The facility shall not permit skiing in areas known to have avalanches or in temperatures below zero degrees Fahrenheit.

(b) The facility shall ensure that staff members:

1. Are familiar with the terrain; and

2. Carry a ski repair kit when skiing in remote areas.

(c) The facility shall ensure that all children and staff members use ski equipment that is *[appropirate]* ***appropriate*** for each person's height, weight and ability and that bindings are secure.

(d) The facility shall ensure that all children and staff members wear appropriate clothing, gloves and eye protection.

10:127-9.12 Solos (solitary activities)

(a) The facility shall ensure that children freely consent to do a solo, defined as a camping experience where a child is living away from direct supervision of staff members, and shall not coerce or force the children to do a solo.

(b) The facility shall:

1. Limit solos to a maximum of 72 hours;

2. Ensure that children know the boundaries of the solo activity; and

3. Advise children they are prohibited from making fires and from rock climbing.

(c) The facility shall ensure that the children receive the following equipment:

1. A whistle to signal for help;

2. Shelter such as a tent or tarpaulin;

3. Three liters of water a day;

4. Food sufficient for three meals a day;

5. A flashlight; and

6. At least one change of clothes appropriate for the weather.

(d) The facility shall ensure that staff members:

1. Communicate with the child at least twice a day by whistle, radio or other means to check on his or her safety and document all contacts in the shift log; and

2. Are available to provide face-to-face contact and care immediately if a child requests attention from staff members.

(e) The facility shall not allow children to do a solo in areas with bodies of water deeper than four feet or in areas having rivers or streams with a strong water current.

10:127-9.13 Swimming

(a) A facility using off-grounds swimming facilities that are not supervised public recreational bathing facilities shall ensure that at least one staff member has a valid lifesaving or lifeguarding certificate issued from an organization that is recognized by the New Jersey State Department of Health or out-of-State health department or other appropriate authority when up to eight children are present, and two staff members have a valid lifesaving or lifeguarding certificate when nine or more children are present.

1. Whenever nine or more children are swimming, the facility shall ensure that at least one lifeguard remains out of the water and is located in a position where he or she can observe all swimmers.

2. No staff member shall assume lifeguarding responsibility for more than three hours without a break.

(b) The facility shall prohibit swimming:

1. In swift and rough water;

2. At night time;

3. Under docks; and

4. When the water temperature is less than 55 degrees Fahrenheit.

(c) The facility shall test each child's swimming ability. If a child cannot swim 100 feet, tread water for three minutes and swim under water for 10 feet, the facility shall ensure that the child wears a life jacket whenever he or she is in water over four and one-half

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feet deep or less if the water is over the child's head, unless under direct supervision for swimming instruction. The facility shall ensure that the life jacket:

1. Indicates a Class I, Class II, or Class III personal flotation device (PFD) rating by the U.S. Coast Guard; and

2. Is never used as a cushion for sitting or kneeling at any time.

(d) The facility shall provide staff members with the following equipment:

1. Whistle; and

2. Ring buoy with rope.

10:127-9.14 Water skiing

(a) The facility shall ensure that:

1. No water skiing occurs after sunset or before sunrise;

2. No water skiing occurs in water that has debris;

3. The water skier wears a personal flotation device (PFD) rated Class II or III by the U.S. Coast Guard;

4. A staff member or responsible child other than the boat driver sits in the boat and acts as an observer of the water skier;

5. There is one staff member for every six additional children on the dock or on land; and

6. The motor boat used for water skiing meets all of the regulations as specified in N.J.A.C. 10:127-9.10.

10:127-9.15 Camping

(a) The facility shall obtain and maintain on file at the administrative office all permits, certificates or licenses that are required by the host state and local governments when using a campsite.

(b) The facility shall ensure that all campsites it utilizes are located in areas that are well-drained and free of observable seepage.

(c) The facility shall ensure that all tents, teepees and canvas on covered wagons are:

1. Made of fire retardant material; and

2. Made of waterproof material that have seams that are coated to resist water.

(d) The facility shall ensure that cabins, tents that are designed for two or more children, teepees and covered wagons when used for sleeping provide:

1. At least 20 square feet per person (for teepees, usable space is measured from the four foot level from the ground and does not include space taken up by any inside liners);

2. At least 30 inches betwen beds and sleeping bags;

3. At least six feet between heads of sleepers; and

4. Cross ventilation.

(e) The facility may follow the manufacturer's tent capacity instead of the requirements identified in (d) above when children and staff utilize a tent(s) for three days or less.

(f) The facility shall prohibit smoking of tobacco products and cooking in all tents, teepees and covered wagons.

(g) The facility shall ensure that male and female children do not sleep in the same quarters.

(h) If the facility uses sleeping bags instead of beds or bed linens, the facility shall ensure that sleeping bags are:

1. Flame resistant;

2. When in use, aired at least every five days and cleaned at least once a month and more often if necessary;

3. Sufficient for the temperatures where the sleeping bags will be used, as indicated by the manufacturer's label; and

4. Placed on a mat or padding when the air temperature at night is below 35 degrees Fahrenheit.

(i) If the facility uses bunk beds, the facility shall ensure that bunk beds:

1. Have railings on top bunks that are no more than 3½ inches from the top of the bed frame;

2. Have mattresses that are at least five inches from the top of the railing; and

3. Are limited to two in height.

(j) If the facility uses latrines instead of toilets, the facility shall ensure that all latrines:

1. Provide for privacy;

2. Are dug at least six feet deep; and

3. Are at least 100 feet ***to 200 feet*** from the campsite and bodies of water***, based on accepted practice and local terrain***.

(k) The facility using latrines shall ensure that there is one latrine for every 10 persons.

(l) Facilities using cabins, tents or teepees for over seven continuous days shall ensure that:

1. There is one shower or bathtub for every 10 children and staff members;

2. The children have access to bathing facilities every day during normal waking hours; and

3. The children have privacy when bathing.

(m) Facilities that camp overnight for seven or fewer continuous days shall ensure that children have access to bathing facilities or are provided with other means of maintaining personal hygiene. These may include, but are not limited to, wet towels, dry shampoo and using showers in schools or in other public facilities.

(n) Whenever regular plumbing facilities are not available for bathing or washing, the facility shall:

1. Ensure that all washing is done with biodegradable non-detergent soap; and

2. Prohibit all washing and bathing in lakes, rivers and streams.

10:127-9.16 Requirements for wagon trains

(a) The facility shall ensure that the canvas and wagon wheels are in good repair.

(b) If horses are used, the facility shall ensure that the requirements regarding the care of horses, as specified in N.J.A.C. 10:127-9.8, are met.

(c) If animals other than horses are used, the facility shall:

1. Limit travel to 10 hours a day;

2. Water the animals at least every four hours;

3. Develop and maintain on file a feed plan; and

4. Check the animals daily for broken hooves and bones.

10:127-9.17 Health and sanitary practices

(a) Before a child participates in a scheduled adventure activity, the facility shall ensure that the child has had a health examination performed by a licensed physician that documents:

1. That the child can perform each type of adventure activity that he or she will be asked to do;

2. Receipt of a tetanus shot or booster shot as appropriate;

3. Notation of asthma, allergies or dietary needs; and

4. Notation of whether the child is on medication that would require the child to avoid using sun screen and/or to take other special precautions.

(b) Within 30 days of a child's forthcoming participation in an adventure activity, the facility shall document in writing and maintain on file in the child's record that the child's current health status, as determined by a physician or nurse in consultation with a physician, allows the child to engage in the specified adventure activity.

(c) The facility shall develop and give to each staff member a written policy for treating:

1. Snake, animal and insect bites; and

2. *[Ingestion of or contact]* ***Contact*** with poisonous plants.

(d) The facility shall ensure that all perishable food is refrigerated at a temperature of 45 degrees Fahrenheit or lower.

(e) The facility shall ensure that all non-disposable utensils used for eating and preparing food are:

1. Not used by another person before rewashing;

2. Washed and rinsed in water that is at least 180 degrees Fahrenheit or water that has been sanitized chemically; and

3. Free of cracks.

(f) The facility shall ensure that all water in streams and lakes that is used for drinking, food preparation and dishwashing is boiled, filtered or purified with iodine or tablets specifically designed to purify water.

(g) The facility shall corral or tie the animals, other than household pets, in an area located at least 50 feet from any areas where food is prepared, cooked or served.

(h) The facility shall:

1. Use fly repellants as necessary;

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2. Remove manure daily to a distance of at least 100 feet from the campsite, cooking and dining areas; and

3. Dispose of animal wastes through burial in a sanitary manner.

10:127-9.18 Qualifications for staff supervising adventure activities

(a) The facility shall comply with the applicable rules specifying criminal disclosure, academic credentials, and years of experience for the director, social service staff, and direct child care staff as specified in N.J.A.C. 10:127-5.1, 5.2 and 5.3.

(b) For all ropes initiatives, rock climbing and water activities, except swimming at supervised public recreational bathing facilities, the facility shall ensure that:

1. The adventure activity program is certified by an organization with recognized expertise in the applicable activity; and/or

2. At least one staff member is certified to conduct the adventure activity.

(c) For land activities other than ropes initiatives and rock climbing, the facility shall ensure that at least one staff member:

1. Is certified to conduct the adventure activity; or

2. Has had at least one year of experience and demonstrated skill in the adventure activity for which he or she will be supervising children.

(d) The facility shall ensure that for each adventure activity there is at least one staff member present who is currently certified in first aid and cardiopulmonary resuscitation (CPR), as defined by a recognized health organization (such as the American Red Cross).

(e) The facility shall ensure that for each adventure activity there are at least two staff members present who are currently certified in first aid and CPR when there are nine or more children present.

10:127-9.19 Staff to child ratio requirements

(a) When children are engaged in an adventure activity, the facility shall ensure that:

1. There is at least one staff member present when there are eight or fewer children engaged in an adventure activity as specified in N.J.A.C. 10:127-9.5(c)1 and 9.18(d).

2. There are at least two staff members present when nine or more children are engaged in an adventure activity as specified in N.J.A.C. 10:127-9.5(c)2 and 9.18(e); and

3. If more than 12 children are involved, there is one staff member for every additional six children.

(b) For purposes of determining whether a required staff ratio is met, only those staff members who are providing direct care and supervision of the children shall be counted. These staff may be regular staff members or adventure staff members.

10:127-9.20 Special requirements for communication and visiting

(a) The requirements in this section shall apply only to facilities providing or contracting for adventure activities that:

1. Are located in areas that are remote or away from ordinary means of communication; or

2. Use travel, including, but not limited to, backpacking, sailing or a wagon train.

(b) The facility shall permit family members, the Division's case manager or other placing agency to visit the child where he or she is currently living and shall provide comfortable inside space when the weather prohibits outside visitation.

1. The facility shall provide privacy for all visits between the child and the Division's case manager or other placing agency.

2. The facility shall provide privacy for family visits unless the facility documents in the child's record that the child would be at risk during a private family visit.

(c) The facility shall develop and maintain on file, in the administrative office, plans and procedures to ensure that each child:

1. Can receive an emergency message from his or her family and from the Division's case manager or other placing agency within 24 hours of the family member or the Division's case manager or other placing agency contacting the facility's administrative office;

2. Is given necessary postage to send mail to family members, the Division's case manager or other placing agency; and

3. Can receive mail from his or her family and the Division's case manager or other placing agency on a weekly basis.

(d) The facility shall permit each child to make private telephone calls to the Division's case manager or other placing agency, upon reasonable request.

(e) The facility shall permit each child to make a telephone call at the facility's expense to a family member at least every other week.

1. The facility may impose a time limit of 15 minutes on telephone calls made by children to family members.

2. The facility may require children to telephone family members at off-peak times.

3. The facility shall not use electronic devices to monitor children's telephone calls to family members, but may observe their reaction during the telephone call.

4. The facility shall maintain documentation that children were permitted to make telephone calls at the facility's expense to family members. Such documentation may include, but is not limited to, copies of telephone bills or notes in logs.

(f) The facility shall not prohibit a child from receiving messages or mail or from making bi-weekly telephone calls as a consequence for misbehavior.

(g) The facility shall explain its policies and procedures to all families and children upon admission and give parents a written explanation of the policy for visiting and communication. This explanation shall include the procedures for sending emergency messages and mail.

SUBCHAPTER 10. SERVICES FOR PREGNANT AND PARENTING ADOLESCENTS

10:127-10.1 General requirements

(a) Any facility that provides services to pregnant adolescents and adolescent parents caring for their children shall meet all requirements of this subchapter and all applicable requirements of N.J.A.C. 10:127-1 through 9.

(b) The facility shall provide services that include*[, but are not limited to,]* the following:

1. Services regarding paternal involvement;

2. Services to the adolescent's family;

3. Parenting education;

4. Infant stimulation;

5. Health education**, prenatal care, postnatal care*** and physical care of the adolescent mothers and infants;

6. Nutrition; and

7. Life skills development.

(c) The facility shall provide the following indoor space:

1. A private place where adolescents can store their belongings and those of their *[infants' and shall provide the adolescents access to this place]* ***infants, which is accessible to the adolescents*** at all times;

2. Sufficient space to accommodate tables and chairs for all adolescents and on-duty child care staff to eat meals together;

3. Adequate space for the implementation of treatment services including individual counseling sessions, parent training sessions, family counseling sessions and case management planning meetings; and

4. The following additional floor space:

i. At least 70 square feet for the first occupant of a bedroom and 50 additional square feet for each additional occupant. The facility shall not allow more than four occupants, including adolescents and/or infants, to sleep in the same bedroom; and

ii. For each adolescent and infant, at least 30 square feet of common living space, defined as those areas that adolescents and infants can use for socializing or recreation during waking hours. The dining area shall not be included in determining compliance with this requirement, unless the dining area is accessible to adolescents and infants outside of meal time.

(d) The facility shall maintain all indoor areas in a safe and sanitary manner by ensuring that:

1. There are no poisonous plants;

2. Any corrosive agents, insecticides, bleaches, detergents, polishes, any products under pressure in an aerosol spray can, and any toxic substances are stored in locked cabinets or enclosed in areas not accessible to infants;

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3. All electrical outlets accessible to infants have protective covers;
4. All fluorescent tubes and incandescent light bulbs have protective covers or shields;
5. All windows and other glass surfaces that are not made of safety glass and that are located within three feet above the floor shall have protective guards unless the facility does not provide services to ambulatory infants or toddlers;
6. Staff has access to any bedrooms that the adolescents are allowed to lock;
7. Non-permanent safety barriers (safety gates) are installed to prevent infants from falling down stairs, ramps, balconies, porches or elevated play areas;
8. Materials and furniture for indoor and outdoor use are of sturdy and safe construction, easy to clean and free of hazards that may be injurious to adolescents and infants;
9. Infants are kept away from hot stoves, irons and ironing boards, knives, glassware and other equipment that may cause injury; and
10. Poisons, insect traps, and rodent traps are kept out of the reach of infants.

(e) The facility shall maintain all outdoor areas in a safe and sanitary manner by ensuring that:
1. Non-permanent safety barriers (safety gates) are installed to block steps used by infants, unless the steps are blocked by a door;
2. Snow is removed from sidewalks and from the walkways and paths leading to the entrances and exits of the facility:
i. Within 24 hours of cessation of snowfall; or
ii. According to local ordinance; and
3. All drains and wells have protective coverings.

(f) The facility shall provide a crib for each infant under 18 months of age but may allow infants to sleep in a playpen or on a mat at least one inch thick on the floor for naps during the daytime.

(g) The facility shall provide a crib or bed for each infant 18 months of age or older.

(h) The facility shall ensure that:
1. Crib and playpen slats are no more than 2⅜ inches apart;
2. Crib, bed and playpen mattresses are fire retardant;
3. The top rails of the crib or playpen are at least 19 inches above the mattress;
4. Any locks or latches on the dropside of a crib are safe from accidental release;
5. The mattress used in all cribs and playpens fits snugly;
6. Each infant has sheets, blankets and other coverings for his or her exclusive use, which are:
i. Immediately replaced when wet, soiled or damaged; and
ii. Laundered at least once a week;
7. Cribs and playpens are free of hazards including, but not limited to, use of mobiles (for infants six months of age or older) and excessive toys; and
8. Beds or cribs not used solely for a specific infant shall have linens and blankets replaced with clean linens and blankets before each use.

(i) The facility shall provide beds for all adolescents.

(j) The facility shall prohibit the use of bunk beds for pregnant adolescents, adolescent mothers and infants.

10:127-10.2 Staff and staff ratio requirements

(a) The facility shall only employ staff members who are at least 21 years of age.

(b) Facilities may use student interns and volunteers as specified in N.J.A.C. 10:127-5.5 to support the activities of regular paid staff members. However, student interns and volunteers below the age of 21 years shall not be permitted to provide activities or transportation by themselves.

(c) Facilities that serve three or more pregnant or parenting adolescents shall have at least one staff person who is certified in first aid and CPR, as defined by a recognized health organization (such as the American Red Cross) in the facility during periods of operation.

(d) Facilities serving three or more adolescents shall have a minimum of two staff on duty at all times. Once this minimum is met, the following staff ratios shall be used to determine staff ratio requirements for the actual number of adolescents and infants present in the facility:

| Adolescents and/or Infants Present in the Facility | Staff Ratio Requirement |
|---|---|
| Waking Hours—Infants only | 1 staff: 4 infants |
| Waking Hours—Adolescents only | 1 staff: 6 adolescents |
| Waking Hours—Adolescents and their infants | 1 staff: 6 residents |
| Sleeping Hours—Adolescents with or without infants | *1 staff: 6 residents |

*At least one staff member shall be awake.

(e) A facility may permit an adolescent to care for another adolescent's infant if the following conditions are met:
1. The adolescent who is assuming the care of another adolescent's infant cares for no more than one other infant in addition to her own at any one time;
2. The adolescents discuss the expectations of the caregiver, including duration of child care, infant's nutritional and toileting needs, and whether the mother will make arrangements for compensation; and
3. The facility documents approval of the arrangement, including how these arrangements will protect the health and well-being of the infants.

10:127-10.3 Staff development and training

(a) Upon employment, the facility shall document in each staff member's personnel record that each staff member received instruction in:
1. The facility's statement of purpose; and
2. Protocols for administering medication.

(b) The facility shall develop, document, and maintain on file a training plan to ensure that the director, social service worker(s) and child care staff receive a total of at least 24 hours of training each year that includes at least one hour of training in each of the following topics:
1. Recognizing and reporting child abuse and neglect;
2. Evacuating the facility;
3. Infant and adolescent growth and development;
4. Discipline of adolescents and infants;
5. Infant care and stimulation;
6. Drug*, **tobacco*** and alcohol abuse;
7. Human sexuality and AIDS prevention; and
8. Depression and suicide prevention.

(c) The facility's training plan may include in-depth discussions at staff meetings, attendance at workshops, conferences or relevant college courses.

(d) The facility may train staff in evacuating the facility, infant care and development, infant discipline, drug*, **tobacco*** and alcohol abuse, and human sexuality and AIDS prevention by including staff in instructional programs attended by the adolescents.

10:127-10.4 Case management requirements

(a) The facility shall develop, implement and maintain on file a written case management plan for each adolescent and her infant.

(b) The facility shall form a case management planning team that is responsible for the development of a case management plan for each adolescent and infant. The team shall consist of each of the following:
1. Staff members representing the clinical and social work components;
2. Staff members representing the child care component;
3. Staff members representing the administration of the facility, if necessary;
4. Representatives from the adolescent's responsible school district and/or current school district, if necessary;
5. A representative from the Division or other placing agency;
6. The adolescent's family, if appropriate; and
7. The infant's father or paternal relatives, if appropriate.

(c) The facility shall document in the adolescent's and infant's record that the Division's case manager or other placing agency representative, the adolescent's therapist, parents or legal guardian, and the responsible and/or current school district, if applicable, were

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invited to participate as members of the case management planning team and in all subsequent revisions of the plan.

(d) The facility shall develop the initial case management plan within 30 calendar days following an adolescent's and/or her infant's admission and shall review or revise the plan at least every three months thereafter.

(e) The case management plan shall include the following information:

1. The name of the adolescent, and infant, if applicable;
2. The date of admission of the adolescent, and infant, if applicable;
3. The date when the plan is developed or revised;
4. The names and titles of all persons attending the development and review meeting;
5. The adolescent's plan for and receipt of medical and dental care;
6. The infant's plan for and receipt of medical care, and dental care if the infant is three years of age or older;
7. Documentation that a referral to the Supplemental Feeding Program for Women, Infant and Children (WIC) was made and that any necessary follow up was done, or documentation that the adolescent or infant was ineligible for WIC;
8. The adolescent's social, familial, emotional and behavioral strengths and weaknesses;
9. An assessment of the infant's father's interest in the child, including a notation of whether the infant's paternity has been legally established;
10. An assessment of the adolescent's parenting capabilities including, but not limited to, the adolescent's ability to feed and play with her infant, provide for her infant's grooming, provide medical care, and use child care responsibly, if applicable;
11. An assessment of the adolescent's academic progress, including a report of attendance and grades obtained within 30 calendar days of the case planning meeting;
12. An assessment of the health and development of the infant, including available developmental assessments from health examinations;
13. Specific treatment goal(s) and objectives in each program area and a projected time frame for completing each goal and objective;
14. The name of the person responsible for the implementation of each treatment goal and objective;
15. Techniques to be used to achieve each treatment goal and objective;
16. Criteria to be used to determine whether each treatment goal is achieved;
17. Notation of progress made from any previous plan;
18. Efforts to achieve timely discharge, including but not limited to services needed by parents or other persons to whom the adolescent will be discharged; and
19. Documentation of how the adolescent is being prepared for self-sufficiency. This documentation shall include, but not be limited to instruction in:

i. Food preparation, including participation in preparing at least one meal a week and training in food shopping at least once a month;

ii. Budgeting and money management, including, but not limited to, discussion of standard deductions from a paycheck, costs for housing and transportation and how to open and use a savings and checking account; and

iii. Career planning and job training, including, but not limited to, discussion of entry level requirements for job openings in the community and assistance in obtaining the qualifications for these positions.

(f) The facility shall send to the Division's case manager or other placing agency a copy of the case management plan and any revisions to it within 30 calendar days after the planning meeting and retain a copy of the correspondence in the adolescent's and infant's record.

(g) The facility shall explain to the adolescent, her parents, and all persons responsible, the adolescent's and infant's case management plan and any revisions to it. If the facility does not explain the adolescent's and infant's case management plan to the adolescent's parents, the facility shall document in the adolescent's case record the reasons that the plan was not explained to the parents.

(h) The facility shall provide and monitor all services specified in the case management plan and document the rationale for any deviations from the most recent case management plan in the adolescent's and infant's record.

(i) When an adolescent mother expresses interest in surrendering her infant for adoption, the facility shall:

1. Explain to the adolescent mother the implications and process of adoption;
2. Notify the Division's case manager or other placing agency;
3. Notify the adolescent's parent or legal guardian, if applicable; and
4. Provide the adolescent with information in order to contact legal counsel if she so chooses.

10:127-10.5 Discharge planning requirements

(a) For discharges that can be anticipated at least 30 calendar days ahead of time, the facility shall develop a plan with the Division's case manager or other placing agency at least 30 calendar days before the adolescent's or infant's discharge. The plan shall specify the following information:

1. The date of admission;
2. The anticipated date of discharge;
3. Details of the events and circumstances leading to the decision to discharge;
4. The name and address of the individual or agency to whom the adolescent or infant will be discharged and the rationale for planning a discharge to that individual or agency;
5. An assessment of the adolescent's continuing needs, including, but not limited to, consideration of health care, behavior management and educational or vocational training; and
6. An assessment of the infant's continuing needs, including, but not limited to, consideration of health and child care and referral to the Supplemental Feeding Program for Women, Infants and Children (WIC).

(b) For discharges that were not anticipated at least 30 calendar days ahead of time, the facility shall send the Division's case manager or other placing agency a written plan at least 10 working days prior to the adolescent's or the infant's discharge. This plan shall specify the following information:

1. The date of admission;
2. Details of the events and circumstances leading to the discharge;
3. Efforts made to locate a runaway, if applicable;
4. An assessment of the adolescent's continuing needs, including but not limited to health care, behavior management and educational and vocational training;
5. An assessment of the infant's health and child care needs, if applicable; and
6. Recommendations for providing follow-up services in the adolescent's or infant's new environment, including consideration of whether the adolescent or infant would be eligible for WIC.

(c) For emergency discharges that result in the immediate placement of the adolescent or infant in a facility such as a detention center, hospital, psychiatric facility or any other placement outside the facility, the facility shall notify the Division's case manager or other placing agency by the next working day by telephone. The facility shall send a written discharge plan within 15 days after the adolescent's or infant's discharge. This plan shall specify the information outlined in (b)1 through 6 above.

10:127-10.6 Services regarding paternal involvement

(a) The facility shall explain to the adolescent mother:

1. The benefits of establishing paternity for her infant and her options for establishing paternity;
2. How to establish paternity of the infant, including:

i. Clarification that naming a father on her infant's birth certificate does not establish paternity unless she is or was married to the infant's father; and

ii. Information about the procedures for establishing paternity;

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3. How to deal with future questions her infant may have about his or her father;

4. How to manage visitation arrangements between her infant and the infant's father; and

5. That establishing paternity is not a condition for remaining in the facility.

(b) The facility shall discuss the topics specified in (a) above in individual or group meetings with adolescent mothers and assist the adolescent in establishing paternity if she so requests. These individual or group meetings shall be held:

*[i.]***1.*** Weekly for facilities that discharge the adolescents soon after they deliver; and

*[ii.]***2.*** At least monthly for facilities that continue to provide services to the adolescents and their infants after delivery.

(c) When the infant's father is known and the adolescent mother agrees, the facility shall attempt at least two in-person contacts with him within two months of the adolescent's admission to the facility to discuss his interest in his child.

1. If the father does not respond to initial contacts made by the facility, the facility shall send a certified letter to all known addresses where the father may be residing indicating the facility's interest in discussing his involvement with his child.

2. The facility shall not be obligated to comply with (c)1 above if it documents that the father's involvement would place the adolescent or infant at physical or emotional risk.

(d) The facility shall allow the fathers of infants residing in the facility to attend parenting classes provided by the facility.

10:127-10.7 Services to the adolescent's family

(a) The facility shall attempt two in-person contacts with the adolescent's parents, or other adult relatives that are responsible for the adolescent if the parents are not available, within two months of the adolescent's admission to discuss the case management plan.

1. If the adolescent's parents or other responsible adult relatives do not respond to the initial contacts, the facility shall send a certified letter to all known addresses where they may be residing indicating the facility's interest in discussing their involvement with their daughter and grandchild.

2. The facility shall not be obligated to comply with (a)1 above if it documents that the family's involvement would place the adolescent or infant at physical or emotional risk.

10:127-10.8 Parenting education

(a) The facility shall have a written curriculum or guidelines for providing parenting education that shall include*[, but not be limited to,]* the following topics:

1. Infant and child development including alternatives to punishment and options for toilet training;

2. Age-appropriate stimulation, games and other recreational activities for children;

***3. Infant safety issues, such as care for the infant while bathing;***

*[3.]***4.*** Providing for child care;

*[4.]***5.*** Health and nutritional care including an explanation of the Supplemental Feeding Program for Women, Infants and Children (WIC);

*[5.]***6.*** Relationships with the adolescent mother's family;

*[6.]***7.*** Dealing with feelings about the adolescent's relationship with the infant's father; and

*[7.]***8.*** Options for placing the infant in a separate foster care placement or for adoption.

(b) The facility shall provide parenting education on a group or individual basis to each adolescent.

(c) The facility shall provide each adolescent at least one hour of parenting education each week until the facility documents that the adolescent has mastered skills or resolved issues specified in (a) above.

(d) The facility shall involve the adolescent in shopping for her infant's clothes and other necessities.

(e) The facility shall provide information to the adolescent on preventing child abuse and neglect, including, but not limited to:

1. Discussion of mandatory reporting;

2. How to identify and report abuse and neglect; and

3. Resources to help parents avoid abusing or neglecting their children.

10:127-10.9 Infant stimulation

(a) The facility shall ensure that all infants under three months of age are held and spoken to, and placed in a position to observe group activity when they are awake during daytime hours.

(b) The facility shall ensure that infants up to six months of age are held by their mother or staff members throughout all bottle feedings and that older infants are held if they are incapable of holding a bottle on their own.

(c) The facility shall ensure that all infants have toys that are accessible to them in their bedrooms.

(d) The facility shall ensure that when adolescent mothers are in school or working, their infants are cared for, either in the facility, in a licensed child care center or in a licensed or registered family day care or group day care home.

(e) Facilities that provide services to adolescent mothers and infants between three and 18 months of age shall ensure that the adolescent mothers engage in at least four of the following activities with their infants for at least a total of 45 minutes each day:

1. Sensory activities: crib mobiles, teething toys, busy boxes, baby mirrors, rattles, melody chimes, squeeze toys, or other comparable supplies or equipment;

2. Language activities: picture books, toy telephones, records, hand puppets, stuffed animals, soft washable dolls, photographs, or other comparable supplies or equipment;

3. Manipulative activities: squeeze and grip toys, boxes, sorting and stacking toys, three or four-piece wooden inlay puzzles, puzzle blocks, simple threading toys, mobile pull toys, balls, or other comparable supplies or equipment;

4. Building activities: soft lightweight blocks, toy cars, trains or boats, figures of animals and people, stacking rings or cups, nesting toys, or other comparable supplies or equipment;

5. Large muscle activities: low climbers, slides, riding or rocking toys, foam or soft plastic balls, gym mats, play tunnels, or other comparable supplies or equipment; or

6. Music activities: rhythm instruments, record player and records, toys equipped with musical tones, musical mobiles, busy boxes, drums, xylophones, pianos, or other comparable supplies or equipment.

(f) Facilities that provide services to adolescent mothers and infants 18 months of age and older shall ensure that adolescent mothers engage in at least four of the following activities with their child for at least a total of 45 minutes each day:

1. Language activities: reading a book, playing with flannel boards, pictures for discussion, materials for recognition, identification or classification, puppets, audio-visual equipment, or other comparable supplies or equipment;

2. Science and math activities: plants and gardening equipment, aquarium with fish or other appropriate live animals, water table and supplies, sand table and supplies, cooking supplies, weather chart, thermometer, counting equipment, or other comparable supplies or equipment;

3. Manipulative activities: puzzles, pegs and pegboards, lacing boards, table top building toys, stencils, dominoes, pounding bench, lotto games, or other comparable supplies or equipment;

4. Large muscle activities: rocking boat, wheel toys, climbers, slides, balance beam, barrels, large cartons, parachute, balls and beanbags, outdoor play equipment, gym mats, or other comparable supplies or equipment;

5. Building activities: unit blocks (minimum of four sizes), transportation toys, farm animals, play people, work bench and tools, table top building toys, building logs, or other comparable supplies or equipment;

6. Art activities: crayons, tempera paint, large brushes and newsprint, finger paint and finger paint paper, construction paper in assorted colors, paste or glue, blunt scissors, collage materials, non-toxic felt tip markers, easels, clay or playdough, or other comparable supplies or equipment; or

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7. Music activities: record player and records, piano, organ, guitar, rhythm sticks, drums, cymbals, bells, tape recorder, or other comparable supplies or equipment.

(g) The facility shall ensure that television watching is not used as a substitute for mother-child interaction.

10:27-10.10 Infant toys and equipment

(a) The facility shall only use infant and play equipment that is sturdy and of safe construction, non-toxic and free of hazards.

(b) The facility shall have a choker tube to ensure that all parts of all toys used by infants under three years of age are large enough so they cannot be swallowed by the infants.

(c) The Bureau may also require the facility to take other necessary precautions to promote toy and equipment safety in keeping with recommendations of the United States Consumer Product Safety Commission.

10:127-10.11 Recreation

(a) In addition to the requirements specified in N.J.A.C. 10:127-6.8, the facility shall encourage each adolescent to use her leisure time productively by documenting in the adolescent's case management plan the facility's efforts to:

1. Inform the adolescent of appropriate activities for herself and her infant in the community;

2. Teach the adolescent how to manage time and money, and to be able to participate in recreational activities; and

3. Teach the adolescent how to use public transportation so she and her infant can go to activities in the community.

(b) The facility shall organize monthly outings or planned group activities within the facility for adolescents and their infants.

10:127-10.12 Money and allowance

(a) The facility shall provide opportunities for all adolescents to earn an allowance, unless the adolescent is receiving AFDC benefits.

(b) The facility shall not require an adolescent to assume responsibility for expenses for her care or that of her infant, except for amounts needed to pay for damage done to the facility by the adolescent or her infant.

1. When an adolescent damages the building or the facility's property, the facility shall identify who damaged the building or property in an incident report before requiring the adolescent to pay restitution.

2. When an infant damages the building or the facility's property, the facility shall identify who damaged the property and that the damage resulted from a lack of supervision by the adolescent mother, before requiring the adolescent mother to pay restitution.

3. The restitution payments shall not exceed 50 percent of an adolescent's weekly income from allowance and earnings.

4. Adolescents who are working or have a savings account shall have the option to make a lump sum payment for damages.

5. The facility may offer the adolescent the option of performing additional chores in lieu of restitution payments.

10:127-10.13 Visiting and communication

(a) The facility shall ensure that the adolescents and infants are allowed to have regular contact with family members, including the infant's father.

1. The facility may designate hours for family visits provided that there are at least three opportunities for families to visit each week.

2. The facility may limit family members' visits to designated places within the facility provided that family members visiting with the infant have access to equipment and toys that can foster communication with the infant.

(b) The facility shall develop a visiting policy and explain the visiting policy to the adolescent and her parent(s) at intake. The visiting policy shall specify:

1. How visiting may be arranged;

2. That family visits shall not be denied for an adolescent's infraction of rules, but may be denied as part of a case management plan after consultation with the Division's case manager or other placing agency;

3. That family members who are under the influence of drugs or alcohol shall not be allowed to transport the adolescent or her infant;

4. That the adolescent and infant may visit with representatives from the Division or other placing agency upon request and that these visits shall not be denied for any reason;

5. The hours when an adolescent may visit with friends and whether the adolescent's visits with friends may be curtailed for infraction of the rules;

6. That the facility may overrule an adolescent's arrangements for leaving her infant with persons living outside the home; and

7. That family members, including the infant's father, shall not be denied visitation unless the facility documents how they pose a risk to the infant or adolescent.

10:127-10.14 Behavior management

(a) Staff members shall follow all the requirements as specified in N.J.A.C. 10:127-6.14.

(b) The facility shall assign responsibility for the use of restrictive behavior management practices and the discipline, control, and supervision of adolescents to staff members and not delegate that responsibility to other adolescents.

(c) The facility shall prohibit adolescents from using the practices and punishments specified in N.J.A.C. 10:127-6.14 on their own infants or on another infant for whom they are caring.

(d) The facility shall ensure that no staff member or adolescent mother disciplines an infant for refusing to eat or sleep, or for crying or soiling.

10:127-10.15 Comprehensive health plan for pregnant adolescents

(a) The facility shall ensure that all pregnant adolescents receive comprehensive prenatal care including, but not limited to:

1. Monthly visits to an obstetrician or certified nurse mid-wife during the first 28 weeks of gestation;

2. Biweekly visits to an obstetrician or certified nurse mid-wife from the 29th to 36th week of gestation;

3. Weekly visits to an obstetrician or certified nurse mid-wife from the 36th week of gestation until delivery;

4. Child birth classes provided by a registered nurse or child birth educator; and

5. A post partum visit within six weeks of delivery.

(b) The facility shall ensure that pregnant adolescents make up missed medical appointments.

(c) The facility shall refer all pregnant adolescents to the Supplemental Feeding Program for Women, Infants and Children (WIC) and make necessary follow-up, or document that the pregnant adolescent was ineligible for WIC.

(d) The facility shall ensure that arrangements for the birth of the infant are made by the end of the first trimester. If the adolescent enters the facility after the first trimester, the facility shall ensure that arrangements for delivery are made by the second prenatal visit.

1. The facility shall ensure that a system is established to provide background medical information on the pregnant adolescent to the hospital identified for delivery or at the birthing center identified for delivery.

2. The facility shall document that delivery arrangements have been made by recording the name and address of the selected hospital or birth center in:

i. The adolescent's record; or

ii. As part of the administrative record.

(e) The facility shall ensure that a staff member or volunteer accompanies the adolescent to the hospital or birthing center when she is ready to deliver and that the staff member or volunteer remains with the adolescent until health care personnel are assigned to her.

(f) The facility shall arrange for pregnant adolescents to receive a dental examination within three months of admission and every six months thereafter.

10:127-10.16 Comprehensive health plan for infants

(a) The facility shall ensure that infants are referred to the Supplemental Feeding Program for Women, Infants and Children (WIC) and take necessary follow-up, or document that the infant was ineligible for WIC.

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(b) Unless contraindicated by the ***infant's*** physician, the facility shall ensure that adolescent mothers adhere to the following schedule in obtaining health care for infants:

1. At age one month, the infant receives:

i. A physical examination including height, weight, temperature check, and measurement of head and chest circumference; and

ii. A check for PKU, if indicated;

2. Between two and two and one-half months of age, the infant receives:

i. A physical examination, as specified in (b)1i above; and

ii. Immunization for *[diptheria]* ***diphtheria***, tetanus, pertussis (DPT) and Trivalent Oral Polio Vaccine (TOPV);

3. Between three and one-half and four months, the infant receives a physical examination, and immunizations as specified in (b)2 above;

4. Between five and six months, the infant receives:

i. A physical examination, as specified in (b)1i above;

ii. Immunization for DPT; and

iii. A developmental assessment;

5. Between eight and nine months, the infant receives:

i. A physical examination, as specified in (b)1i above;

ii. A hemoglobin test; and

iii. A sickle cell screening, if indicated;

6. Between 11 and 12 months, the infant receives*[;]*****;***

i. A physical examination, as specified in (b)1i above*[.]*****;***

ii. A developmental assessment; and

iii. A tuberculin test;

7. At 15 months, the infant receives:

i. A physical examination, as specified in (b)1i above;

ii. Immunizations for rubella and measles; and

iii. At 15 or 16 months, immunization for mumps;

8. At 18 months, the infant receives:

i. A physical examination, as specified in (b)1i above;

ii. A DPT booster;

iii. A TOPV booster; and

iv. Immunization for hemophilus influenza Type B;

9. At 24 months and annually thereafter (until age five), the infant receives:

i. A physical examination, as specified in (b)1i above;

ii. A developmental assessment;

iii. A hemoglobin test;

iv. Urinalysis, and a tuberculin test if indicated; and

10. At 36 months and semi-annually thereafter, a dental examination.

*[(b)]*****(c)*** The facility shall ensure that the adolescent mother obtains a hemophilus influenza Type B (meningitis) immunization for her child when the child is two years of age, or at the earliest date possible thereafter.

*[(c)]*****(d)*** The facility shall ensure that the adolescent mother has her child's sight and hearing tested when she takes a child over three and one-half years of age for a medical examination. This testing shall be repeated for children ages four and five years old who remain in the facility.

*[(d)]*****(e)*** The facility shall ensure that a child who is five years old receives a DTP booster and a TOPV booster when he or she remains in the facility.

10:127-10.17 Comprehensive health care for adolescent mothers who are not pregnant

(a) The facility shall ensure that all adolescent mothers who are not pregnant and who have not had a health examination within one year prior to admission, receive a comprehensive health examination within 72 hours after admission, unless she has received such a medical examination within 30 days prior to her placement. This comprehensive health examination shall include, but not be limited to, an assessment of:

1. Height and weight;
2. Blood count;
3. Urinalysis;
4. Vision;
5. Hearing; and
6. Gynecological exam.

(b) The facility shall arrange for follow-up medical care recommended as part of the comprehensive health examination.

(c) The facility shall ensure that adolescent mothers receive a dental examination within three months of admission and every six months thereafter.

10:127-10.18 Care of sick infants

(a) When an infant at the facility has an illness or symptom of illness including***,*** but not limited to***,*** those specified below, the facility shall ensure that the adolescent mother or a staff member contacts a licensed physician:

1. Severe pain or discomfort;
2. Acute diarrhea, characterized as twice the child's usual frequency of bowel movements with a change to a looser consistency within a period of 24 hours;
3. Two or more episodes of acute vomiting within a period of 24 hours;
4. Elevated oral temperature of 101.5 degrees Fahrenheit or over, or axillary temperature of 100.5 degrees Fahrenheit or over in conjunction with behavior changes*[.]*****;***
5. Sore throat or severe coughing;
6. Yellow eyes or jaundiced skin;
7. Red eyes with discharge;
8. Infected, untreated skin patches;
9. Difficult or rapid breathing;
10. Skin rashes, excluding diaper rash, lasting more than one day;
11. Weeping or bleeding skin lesions that have not been treated by a physician or nurse;
12. Swollen joints;
13. Visibly enlarged lymph nodes;
14. Stiff neck; or
15. Blood in urine.

(b) The facility shall follow the physician's recommendation whether to permit the infant who is ill to have contact with other infants.

10:127-10.19 General medical practices

(a) The facility shall ensure that any medical, dental, psychological or psychiatric treatment or medication administered to an adolescent is explained to the adolescent.

1. The facility shall ensure that any medical, dental, psychological or psychiatric treatment or medication administered to an infant is explained to the adolescent mother.

2. The facility shall document all of these explanations in the adolescent's record.

(b) When serious accidents or illnesses occur to an infant, the facility shall take necessary emergency action and notify the adolescent, the adolescent's parent(s), if applicable, the Division's *[Case]* ***case*** manager or other placing agency and the Bureau immediately.

(c) When serious accidents or illnesses occur to an adolescent, the facility shall take necessary action and notify the adolescent's parent(s) if she is under 18 years of age, the Division's case manager or other placing agency and the Bureau immediately.

10:127-10.20 Medication

(a) The facility shall ensure that adolescents use only prescription and non-prescription medication that is authorized by a physician.

1. The facility shall permit adolescents to administer medication to their infants and themselves, unless a physician, psychiatrist or psychologist advises otherwise; in such cases, the facility shall document the reasons in the adolescent's record.

2. The facility shall ensure that adolescents follow the advice of the infant's physician for administering medication to their infants.

3. The facility shall supervise the adolescent's administration of all medication she gives to her infant and may require the adolescent to record the information specified in (b) below.

(b) The facility shall maintain a medication log book that contains the following information:

1. The name of the adolescent or infant receiving medication, whether prescription or non-prescription;

2. The type of medication, dosage, and intervals between dosages;

3. What to do if a dosage is missed;

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4. The reason for the medication;
5. The date and time the medication was administered;
6. Possible side effects of the medication, if any; and
7. The signature and title of staff member or adolescent dispensing medication.

(c) The facility shall ensure that the following procedures for storage are followed:

1. Facilities shall keep prescription and non-prescription drugs in a locked cabinet, or, as needed, a locked container in a refrigerator that is inaccessible to infants;
2. External drugs and internal drugs shall be stored in separate locked shelves;
3. All outdated stocks and prescriptions no longer in use shall be disposed of safely, as specified in N.J.A.C. 10:127-7.4;
4. The telephone number of the regional poison control center shall be posted at all medication-dispensing stations and by each telephone; and
5. Medical supplies shall be stored in an area accessible to staff members at all times.

(d) In situations where the facility determines that an adolescent is capable of self-administration of prescription birth control-related supplies, the facility may allow the adolescent to maintain prescription birth control-related supplies among her personal possessions, provided that the facility:

1. Provides a locked cabinet or box for storage; and
2. Documents the rationale and arrangements for the adolescent to maintain prescription birth control-related supplies.

10:127-10.21 Environmental sanitation requirements for disinfecting

(a) The facility shall first wash with soap and water and then disinfect those items specified below with a solution that shall either be:

1. A commercially prepared disinfectant that indicates it kills bacteria, viruses and parasites. This solution shall be used in accordance with label instructions; or
2. A self-made solution consisting of ¼ cup of household bleach to each gallon of water (one tablespoon per quart), which shall be prepared daily and placed in a labeled, sealed container. This self-made solution shall not be utilized with those items specified in (d)2 below.

(b) The facility shall ensure that the following equipment, items or surfaces are washed and disinfected after each use:

1. Toilet training chairs that have first been emptied into a toilet, unless each infant has his or her own toilet training chair;
2. Sinks and faucets used for handwashing, if the sink is also used for rinsing a toilet training chair;
3. Diapering surfaces, used by more than one infant;
4. Toys mouthed by infants before being given to another infant;
5. Mops used for cleaning; and
6. Oral and rectal thermometers.

(c) The facility shall wash and disinfect the following items at least daily:

1. Toilets and toilet seats used by more than one infant;
2. Diaper pails and lids used by more than one infant;
3. Drinking fountains;
4. Water table and water play equipment;
5. Play tables; and
6. Smooth surfaced non-porous floors in areas used by infants.

(d) The facility shall wash and disinfect the following items *[not using a self-made solution as specified in (a)2 above,]* at least weekly, and before use by another infant*[.]***:***

1. Cribs, cots, mats, playpens or other sleeping equipment approved by the Bureau; and
2. Sheets, blankets or other coverings.

(e) The facility shall wash and disinfect tables used by the infant for eating before each meal.

(f) Facilities that maintain outside sandboxes or play areas containing sand shall ensure that:

1. Only asbestos-free sand is used; and
2. The sand is maintained in a safe and sanitary manner.

10:127-10.22 Personal hygiene requirements

(a) The facility shall ensure that adolescents and staff members wash their hands with soap and running water immediately:

1. Before preparing or serving food;
2. After diapering a child;
3. After toileting;
4. After assisting a child in toileting;
5. After caring for a child who appears to be sick;
6. After handling animals or their equipment or after coming in contact with an animal's body secretions; and
7. After coming into contact with blood, fecal matter, urine, vomit, saliva, nasal secretions or other body fluids or secretions.

(b) The facility shall ensure that adolescents or staff members:

1. Change each infant's diaper when wet or soiled; and
2. Wash and dry each infant's bottom during each diaper change with an individual disposable wash cloth, paper towel or disposable diaper wipes.

(c) The facility shall ensure that soiled diapers are placed in a closed container that is lined with a leakproof or impervious lining.

1. Disposable diapers shall be removed from the facility daily and placed in a closed container that is outside the building and used for refuse collection.
2. Non-disposable diapers shall be stored and laundered separately for each child except when the diapers are laundered by a commercial laundry service.

10:127-10.23 Health education and physical care for adolescents and infants

(a) The facility shall ensure that adolescents receive training in personal care, hygiene, and grooming habits.

1. The facility shall discuss the physiological changes experienced during adolescent pregnancy and childbearing with adolescents in the facility.
2. The facility shall instruct adolescents about sexually responsible behavior, including how to protect themselves from pregnancy and sexually transmitted diseases including AIDS.
3. The facility shall instruct all adolescents about the health ***and social*** consequences of cigarette smoking and alcohol and drug use.

(b) The facility shall ensure that each adolescent bathes and grooms her infant daily, and provides other personal hygiene services that are necessary to meet the infant's needs.

1. The facility shall give each adolescent and infant individual towels and washcloths.
2. The facility shall ensure that soap and toilet paper are available for the adolescents and infants at all times.

(c) The facility shall ensure that each adolescent and infant has a personal supply of adequate, clean, well-fitting, and attractive clothing ***and footwear*** appropriate to his or her age, gender, individual needs, community standards, and season.

1. The facility shall ensure that each adolescent's and infant's clothing is kept clean and in good repair. The facility may require adolescents to do their own laundry and that of their infant.
2. The facility shall not require adolescents or infants to wear any article of clothing that would identify them as a resident of the facility.
3. The facility shall supply adolescents with necessary personal hygiene items.

10:127-10.24 Food and nutrition for infants

(a) In addition to the requirements specified in N.J.A.C. 10:127-6.11, the facility shall ensure that each adolescent mother obtains and follows a written plan developed with the infant's health care provider regarding the feeding schedule, specific formula, nutritional needs and introduction of new food for each infant.

1. The facility shall maintain on file the feeding schedule of each infant residing in the facility in the infant's record.
2. The facility shall ensure that the adolescent makes the feeding schedule available to all of the infant's caregivers.

10:127-10.25 Life skills development

(a) The facility shall ensure that the adolescent mothers receive instruction and experience in the following:

1. Meal planning and meal preparation;

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2. Food shopping;
3. Locating affordable housing;
4. Securing appropriate medical and dental services;
5. Utilization of public transportation;
6. Home safety guidelines, including but not limited to:
i. Notifying the local public service or utility company when gas leaks are suspected;
ii. Keeping the child away from a hot stove;
iii. The dangers of open windows when infants are present;
iv. The appropriate methods to rid the home of pests;
v. Fire prevention;
vi. Contacting the appropriate community agency when an emergency occurs;
7. Banking; and
8. Applying for public assistance.
(b) The facility shall document in the adolescent mother's record that she has received the training specified in (a) above.

# CORRECTIONS

## (a)

### STATE PAROLE BOARD

### Parole Board Rules
### Calculation of Parole Eligibility Terms
### Adopted Amendments: N.J.A.C. 10A:71-3.2 and 3.21

Proposed: April 19, 1993 at 25 N.J.R. 1665(a).
Adopted: June 30, 1993 by the New Jersey State Parole Board, Mary Keating DiSabato, Chairman.
Filed: July 16, 1993 as R.1993 d.399, **without change.**
Authority: N.J.S.A. 30:4-123.48(d).
Effective Date: August 16, 1993.
Expiration Date: February 5, 1995.

**Summary** of Public Comments and Agency Responses:
COMMENTS: The Department of Law and Public Safety—Division of Criminal Justice notified the State Parole Board that the Division of Criminal Justice supported the proposed amendments. The Board of Trustees for the Adult Institutions notified the State Parole Board that the Board of Trustees approved of the proposed amendments.

**Full text** of the adoption follows:

10A:71-3.2 Calculation of parole eligibility terms
(a)-(b) (No change.)
(c) The parole eligibility terms for adult inmates shall be determined by the following:
1.-7. (No change.)
8. Where the inmate's actual eligibility date has passed at the time of the initial parole release hearing and the inmate has been denied parole and required to serve a future eligibility term pursuant to N.J.A.C. 10A:71-3.21, a new book date shall be established by adding the additional term to the actual eligibility date and by including, in the case of an adult inmate, commutation credit based on the additional term only.
9. (No change in text.)
(d)-(h) (No change.)

10A:71-3.21 Board panel action; schedule of future parole eligibility dates for adult inmates
(a)-(d) (No change.)
Recodify existing (f)-(j) as (e)-(i) (No change in text.)

## (b)

### STATE PAROLE BOARD

### Parole Board Rules
### Victim Input
### Adopted Amendment: N.J.A.C. 10A:71-3.47

Proposed: December 21, 1992 at 24 N.J.R. 4483(a).
Adopted: June 30, 1993 by the New Jersey State Parole Board, Mary Keating DiSabato, Chairman.
Filed: July 26, 1993 as R.1993 d.410, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).
Authority: N.J.S.A. 30:4-123.48(d) and 123.55 (P.L. 1992, c.59).
Effective Date: August 16, 1993.
Expiration Date: February 5, 1995.

**Summary** of Public Comments and Agency Responses:
1. COMMENT: An Assistant Deputy Public Defender, Allan Marain, indicated that N.J.A.C. 10A:71-3.47(m) provides that once a victim advises of his or her intent to submit a written statement concerning an inmate's parole hearing, a decision must be deferred pending receipt of the statement; that N.J.A.C. 10A:71-3.47(m) contains no provision for the Board to render a decision following non-receipt of the statement; and that such an omission, interpreted literally, would bring parole processing to a halt with no power by the Board to resume processing. The Assistant Deputy Public Defender also noted that a similar impediment existed in N.J.A.C. 10A:71-3.47(n). It was recommended that a time period be established which upon expiration the Board may resume processing of the inmate's case.
RESPONSE: The Board concurred in the assessment that the failure to provide for the Board to render a decision following non-receipt of the written statement could possibly impede the parole processing of an inmate's case. It was not the intent of the Board that the amendments to the rules should preclude the Board's efficient and orderly processing of an inmate's case. Accordingly, the Board elected to amend the respective rules to include a time period of 30 days within which a written statement is to be submitted. The establishment of a time period upon expiration of which the Board may continue the processing of an inmate's case is deemed by the Board to be an appropriate substantive change upon adoption of the rules.
2. COMMENT: An inmate, Jwyanza Kitaka, believed that permitting a victim or victim's relative to appear in person before a Board panel or the Board will shift the focus of the hearing from the accomplishments of the inmate to the emotional expressions of the victim or victim's relative and that allowing a victim or victim's relative to appear at the hearing will deny a prisoner a fair hearing. The inmate also believed that the proposed amendments should apply to prisoners committed after the effective date of the amendments and that to apply the amendments retroactively will violate the prohibition against ex post facto laws.
RESPONSE: The Board does not concur with the assessment that the in person participation of a victim or victim's relative will in any way infringe upon an inmate's entitlement to a fair hearing. Further, the Board does not concur that the amendments to the rule which has provided for victim input since 1984 is a violation of the ex post facto clause.
3. COMMENT: The Prisoners' Representative Committee, East Jersey State Prison, believed that a victim or victim's relative should have knowledge of a prisoner's institutional adjustment and progress during incarceration. The committee believed that this type of information could have an impact on how a victim may feel about a prisoner being released to the community and that the trauma suffered by a victim could be eased if the victim is made cognizant of the fact that a prisoner can alter past behavioral patterns and become a productive member of society.
RESPONSE: The victim input process is intended to provide victims or victim's relatives with an opportunity to present to the Board information pertaining to the impact of the crime on the victim or victim's relative and information that may be relevant in the Board's assessment of an inmate's case. The Board is not of the opinion that it is obligated to act on an inmate's behalf to provide positive information on the inmate to a victim or victim's relative. However, the Board does view the victim input process as a means to inform a victim or victim's relative as to

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the parole processing of an inmate's case and upon the request of a victim or victim's relative the Board and its staff will provide nonconfidential information as to an inmate's progress and adjustment during incarceration.

4. COMMENT: Ronald Walters, Director of Custody, Southern State Correction Facility, informed the Board that an institution should have several days advance notice of hearings that will be conducted with victim input; that those individuals coming to testify must be instructed on having proper identification and instructed to comply with institutional regulations; and that hearings involving victims and/or relatives should be scheduled in a manner that avoids waiting, delays or logistical problems.

RESPONSE: The Board is cognizant that notice of a victim input hearing must be provided to the institutional authorities in a timely manner in order that the necessary arrangements may be completed for the conducting of said hearing. Such notice will be provided by designated staff. Staff will also inform an individual(s) scheduled to appear at an institution for a victim input hearing that proper identification is required to enter the institution and that the individual(s) must comply with institutional rules and regulations. Due to it being the general intent to schedule victim input hearings on the date that a Board panel will be conducting regular parole hearings, the Board is cognizant of the necessity to schedule said hearings in a manner which will preclude unnecessary delays or problems for all participants in the hearings as well as institutional custodial staff. Every effort will, therefore, be made by the Board and its staff to avoid any inconvenience and problems in the scheduling and conducting of victim input hearings.

5. COMMENT: The Office of the Public Defender advised of its concern that the use of both live and taped testimony of victims or members of their immediate family does not provide the inmate with the ability to respond in a meaningful way. Incorrect and misleading information may be submitted without rebuttal testimony. Although the Office of the Public Defender recognizes that the same due process protections afforded to criminal defendants are not applicable in parole matters, the agency believed that fundamental fairness dictates that the inmate have access to this information prior to his appearance before the parole authorities.

RESPONSE: The Board's rule provides that information presented during the victim input process shall not be deemed confidential and shall be released to the inmate unless the withholding of a written statement or testimony is requested by the victim and the hearing officer, Board panel or Board determines that the release of the statement or testimony would endanger the safety of the person providing the statement or testimony. Therefore, unless deemed confidential, information will be released to the inmate. The dissemination of a written statement to an inmate will occur in advance of the conducting of the inmate's panel hearing. However, where testimony is presented to the Board members on the same date as the conducting of the inmate's panel hearing, the Board members will need to verbally inform the inmate of the non-confidential information presented for the Board members' consideration.

**Full text** of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

10A:71-3.47 Victim input

(a) Any victim injured as a result of a crime of the first or second degree or the nearest relative of a murder/manslaughter victim shall be entitled to present a statement for the parole report, filed pursuant to N.J.A.C. 10A:71-3.7, to be considered during the parole hearing process, to present testimony to a senior hearing officer designated by the Board panel, to present testimony to the Board panel, or to present testimony to the Board, if a hearing is conducted pursuant to N.J.A.C. 10A:71-3.19, concerning the victim's harm.

(b) The term "victim" shall mean a person who suffers a personal, physical or psychological injury or death or incurs loss of or injury to personal or real property as a result of a crime of the first or second degree committed against that person, or in the case of murder/manslaughter, the nearest relative of the victim. In the case of a minor, victim shall also mean the minor's parent(s) or guardian.

(c) The term "nearest relative of a murder/manslaughter victim" shall mean a spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half-brother, half-sister and guardian of a minor.

(d) At the time of sentencing, the prosecutor shall notify any victim injured as a result of a crime of the first or second degree or the nearest relative of a murder/manslaughter victim of the opportunity to present a statement for the parole report to be considered during the parole hearing process, to present testimony to a senior hearing officer designated by the Board panel, to present testimony to the Board panel, or to present testimony to the Board, if a hearing is conducted pursuant to N.J.A.C. 10A:71-3.19, concerning the victim's harm.

(e) Each victim or nearest relative of a murder/manslaughter victim shall be responsible for notifying the Board of his or her intent to submit a statement, or to testify, and to provide and keep current an appropriate mailing address.

(f) The statement or testimony of the victim or nearest relative of a murder/manslaughter victim may include the following:

1.-3. (No change.)

(g) At the time public notice is given pursuant to N.J.A.C. 10A:71-3.8, the Board shall notify any victim or nearest relative of a murder/manslaughter victim who has previously contacted the Board of the opportunity to provide a statement for inclusion in the parole report or to present testimony to a senior hearing officer designated by the Board panel, to the Board panel or to the Board, if a hearing is conducted pursuant to N.J.A.C. 10A:71-3.19. The Board shall notify such person at the address of record.

(h) The victim or nearest relative of a murder/manslaughter victim shall notify the Board within 30 days from the date of the notice provided pursuant to (g) above of his or her intent to submit a statement or to testify before a senior hearing officer designated by the Board panel, before the Board panel or before the Board, if a hearing is conducted pursuant to N.J.A.C. 10A:71-3.19. This time period may be waived by the Board for good cause.

(i) Upon the victim or nearest relative of a murder/manslaughter victim submitting a written statement to the Board subsequent to notice being provided pursuant to (g) above, the statement shall be made a part of the Board's file on the inmate and the inmate's case shall be referred to a hearing officer designated to conduct parole release hearings pursuant to N.J.A.C. 10A:71-3.14.

(j) Upon the victim or nearest relative of a murder/manslaughter victim informing the Board subsequent to notice being provided pursuant to (g) above that such person intends to testify before a senior hearing officer designated by the Board panel, the Chairperson shall assign the inmate's case to a senior hearing officer for the purpose of receiving such person's testimony. The case shall be processed as follows:

1. Except as provided in N.J.A.C. 10A:71-3.50, the assigned senior hearing officer shall conduct a hearing within 30 days from the date the Board received notification of the intent to offer testimony.

2. The hearing shall be conducted at a time and place and on a date determined by the Chairperson or designee. Notice of the time, place and date of the hearing shall be provided to the victim or nearest relative of a murder/manslaughter victim in writing and shall be mailed at least 14 days prior to the hearing date.

Recodify existing (k)-(m) as 3. to 5. (No change in text.)

6. The hearing scheduled pursuant to this subsection shall be conducted, when possible, prior to a parole release hearing and prior to the appropriate Board member(s), Board panel or the Board rendering a decision pursuant to N.J.A.C. 10A:71-3.16 and 3.18. However, nothing herein shall be construed to preclude the Board from conducting a timely parole release hearing.

7. During the hearing conducted pursuant to this subsection, only the senior hearing officer, appropriate Board personnel and the victim or nearest relative of a murder/manslaughter victim shall be present in the hearing room. If deemed necessary by the senior hearing officer, a translator may be permitted to assist in the hearing or a family member may be permitted to assist a minor, elderly or infirm victim or nearest relative of a murder/manslaughter victim in the hearing. The senior hearing officer may also permit an individual to be present in the hearing room for the limited purpose of providing emotional support to the victim or nearest relative of a murder/manslaughter victim.

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(k) Upon the victim or nearest relative of a murder/manslaughter victim informing the Board subsequent to notice being provided pursuant to (g) above that such person intends to testify before the Board panel, the case shall be processed as follows:

1. Victim input shall be received by the Board panel on the date of the inmate's scheduled hearing before the Board panel and at the designated institution. However, if deemed appropriate by the Board panel, the victim input may be received by the Board panel at a place and on a date other than at the institution in which the inmate is confined and on the date of the inmate's scheduled hearing before the Board panel. If the two Board panel members cannot reach agreement on an alternate place and date, the matter shall be referred to the Chairperson for a final decision.

2. The victim input segment of the Board panel hearing shall be conducted, with the consent of the Department, in the administrative area of the institution.

3. Notice of the time, place and date of the Board panel hearing shall be provided to the nearest relative of a murder/manslaughter victim in writing and shall be mailed at least 14 days prior to the hearing date.

4. The nearest relative of a murder/manslaughter victim shall be required to confirm with the Board their appearance before the Board panel seven days prior to the hearing date.

5. Upon confirmation by the nearest relative of a murder/manslaughter victim of their appearance before the Board panel, the Board shall notify the Department of the identities of the person(s) who will appear before ***the*** Board panel on the scheduled hearing date.

6. The Board shall notify the nearest relative of a murder/manslaughter victim that appropriate personal identification is required by the Department in order to enter the institution.

7. During the victim input segment of the Board panel hearing, the Board panel shall permit the nearest relative of a murder/manslaughter victim a reasonable opportunity to present information relative to the factors outlined in (f) above or any other information relevant to the Board panel's consideration of the inmate's case. The Board panel shall, in recognition of the number of hearings to be conducted on the hearing date, be permitted to establish a reasonable time period(s) for the presentation of information.

8. The victim input segment of the Board panel hearing shall be recorded by an electronic recording advice and said recording shall be maintained as part of the Board's file on the inmate's case.

9. If a Board panel hearing is cancelled, the Board panel shall provide immediate notification of the cancellation to the nearest relative of a murder/manslaughter victim. The Board panel shall provide reasonable notice of the time, place and date of the Board panel hearing upon the hearing being rescheduled.

10. In the victim input segment of the Board panel hearing, only the Board members, appropriate Board personnel and nearest relative of a murder/manslaughter victim shall be present in the hearing room. If deemed necessary by the Board panel, a translator may be permitted to assist in the hearing or a family member may be permitted to assist a minor, elderly or infirm nearest relative of a murder/manslaughter victim in the hearing. The Board panel may also permit an individual to be present in the hearing room for the limited purpose of providing emotional support to the nearest relative of a murder/manslaughter victim.

11. If a nearest relative murder/manslaughter victim provides notice of their inability to attend the Board panel hearing on the scheduled date, the hearing shall be conducted as scheduled. However, if the hearing on the scheduled date is cancelled, the Board panel shall provide reasonable notice of the time, place and date of the Board panel hearing upon the hearing being rescheduled.

12. Upon the conclusion of the victim input segment of the Board panel hearing, the Board panel shall reconvene the hearing with the inmate present in the hearing room designated by the Department. In the inmate segment of the Board panel hearing, the nearest relative of a murder/manslaughter victim shall not be present in the hearing room.

(l) If a hearing is conducted pursuant to N.J.A.C. 10A:71-3.19, the Board shall notify the nearest relative of a murder victim, who has previously contacted the Board, of the hearing and shall afford the nearest relative of a murder victim the opportunity to testify in person before the Board or to submit a *[writen]* ***written*** statement. If the nearest relative of a murder victim intends to testify before the Board, the case shall be processed as follows:

1. Victim input shall be received by the Board on the date of the inmate's scheduled hearing before the Board and at the designated institution.

2. The victim input segment of the Board hearing shall be conducted, with the consent of the Department, in the administrative area of the institution.

3. Notice of the time, place and date of the Board hearing shall be provided to the nearest relative of a murder victim in writing and shall be mailed at least 14 days prior to the hearing date.

4. The nearest relative of a murder victim shall be required to confirm with the Board their appearance before the Board seven days prior to the hearing date.

5. Upon confirmation by the nearest relative of a murder victim of their appearance before the Board, the Board shall notify the Department of the identities of the person(s) who will appear before ***the*** Board on the scheduled hearing date.

6. The Board shall notify the nearest relative of a murder victim that appropriate personal identification is required by the Department in order to enter the institution.

7. During the victim input segment of the Board hearing, the Board shall permit the nearest relative of a murder victim a reasonable opportunity to present information relative to the factors outlined in (f) above or any other information relevant to the Board's consideration of the inmate's case. The Board shall, in recognition of the number of hearings to be conducted on the hearing date, establish a reasonable time period(s) for the presentation of information.

8. The victim input segment of the Board hearing shall be recorded by an electronic recording device and said recording shall be maintained as part of the Board's file on the inmate's case.

9. If a Board hearing is cancelled, the Board shall provide immediate notification of the cancellation to the nearest relative of a murder victim. The Board shall provide reasonable notice of the time, place and date of the Board hearing upon the hearing being rescheduled.

10. In the victim input segment of the Board hearing, only the Board members, appropriate Board personnel and the nearest relative of a murder victim shall be present in the hearing room. If deemed necessary by the Board, a translator may be permitted to assist in the hearing or a family member may be permitted to assist a minor, elderly or infirm nearest relative of a murder victim in the hearing. The Board may also permit an individual to be present in the hearing room for the limited purpose of providing emotional support to the nearest relative of a murder victim.

11. If a nearest relative of a murder victim provides notice of their inability to attend the Board hearing on the scheduled date, the hearing shall be conducted as scheduled. However, if the hearing on the scheduled date is cancelled, the Board shall provide reasonable notice of the time, place and date of the Board hearing upon the hearing being rescheduled.

12. Upon the conclusion of the victim input segment of the Board hearing, the Board shall reconvene the hearing with the inmate present in the hearing room designated by the Department. In the inmate segment of the Board hearing, the nearest relative of a murder victim shall not be present in the hearing room.

(m) If notice pursuant to (h) above is received subsequent to the conducting of an initial parole hearing but prior to a decision being rendered in the inmate's case, the appropriate Board member(s), Board panel or the Board shall not render a decision in the inmate's case until a written statement is received and made a part of the Board's file on the inmate, a hearing has been conducted pursuant to (j) above and the written report prepared and made a part of the Board's file or a hearing has been conducted pursuant to (k) above. ***If it is the intent of the victim or the relative of a murder/manslaughter victim to submit a written statement, as evidenced by the notification to the Board pursuant to (h) above, the written**

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**statement must be submitted and received by the Board within 30 days of the date of the Board having received the initial notification of intent or the appropriate Board member(s), Board panel or the Board may proceed to render a decision in the inmate's case.***

(n) If notice pursuant to (h) above is received subsequent to the rendering of a decision certifying parole release, the appropriate Board member(s), Board panel or the Board shall suspend the parole release date pursuant to N.J.A.C. 10A:71-5.1 pending the receipt of a written statement or the completion of a hearing pursuant to (j) and the submission of a report or a hearing has been conducted pursuant to (k) above. ***If it is the intent of the victim or the relative of a murder/manslaughter victim to submit a written statement, as evidenced by the notification to the Board pursuant to (h) above, the written statement must be submitted and received by the Board within 30 days of the date of the Board having received the initial notification of intent or the appropriate Board member(s), Board panel or the Board may rescind the suspension of the parole release date.***

1. Within 14 days of submission of a written statement, the report of the designated senior hearing officer or the completion of the hearing pursuant to (k) above, the Board member(s), Board panel or Board shall:

i.-iv. (No change.)

(o) Any and all statements or testimony of the victim or nearest relative of a murder/manslaughter victim submitted to the Board pertaining to the continuing nature and extent of any physical harm or psychological or emotional harm or trauma suffered by the victim, the extent of any loss of earnings or ability to work suffered by the victim and the continuing effect of the crime upon the victim's family shall not be deemed confidential and shall be released to the inmate unless the withholding of the statements or testimony is requested by the victim and the hearing officer, Board panel or Board determines that the release of the statements or testimony would endanger the safety of the person providing the statements or testifying. The Board on its own motion may for good cause identify all or part of the statements or testimony as confidential.

(p) The provisions of this section except for public notice required pursuant to N.J.A.C. 10A:71-3.8 and except for testifying before the Board panel and Board shall be applicable to the cases of juvenile and county inmates.

(q) Nothing in this section shall preclude the Board from receiving statements or testimony from any victim injured as a result of a crime of the third or fourth degree or the nearest relative of a victim. However, statements shall be submitted in writing to the Board and testimony shall be received by a designated senior hearing officer pursuant to (j) above.

(r) (No change in text.)

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## (a)

## STATE PAROLE BOARD

### Parole Board Rules
### Conditions of Parole
### Adopted Amendments: N.J.A.C. 10A:71-6.4 and 7.3

Proposed: February 1, 1993 at 25 N.J.R. 435(a).

Adopted: June 30, 1993 by the New Jersey State Parole Board, Mary Keating DiSabato, Chairman.

Filed: July 16, 1993 as R.1993 d.398, **without change**.

Authority: N.J.S.A. 30:4-123.48(d), 30:4-123.59 (P.L. 1992, c.156) and 30:4-123.60 (P.L. 1992, c.156).

Effective Date: August 16, 1993.

Expiration Date: February 5, 1995.

**Summary** of Public Comments and Agency Responses:

COMMENT: The Prisoners' Representative Committee at East Jersey State Prison informed the State Parole Board that the Committee was not in favor of the proposed amendments and that the proposed amendments will only infringe upon a prisoner's and parolee's rights. The Committee was of the opinion that a parolee after an arrest would lose his right of being presumed innocent until proven guilty; that the possibility of abuse by State bureaucracy is always present; that due to overcrowding basic human needs are not being met adequately; and that an increase in the inmate population will only add to the present problems of providing food, medical and other services to the inmate population.

RESPONSE: The amendments to the New Jersey Administrative Code are based on legislation (P.L. 1992, c.156) signed by the Honorable Jim Florio, Governor, State of New Jersey on November 25, 1992.

**Full text** of the adoption follows:

10A:71-6.4 Conditions of parole

(a) The certificate of parole shall contain the following general conditions of parole:

1.-5. (No change.)

6. You are not to own or possess any firearm, as defined in N.J.S.A. 2C:39-1f, for any purpose.

7. You are not to own or possess any weapon enumerated in N.J.S.A. 2C:39-1r.

8. You are to refrain from the use, possession or distribution of a controlled dangerous substance, controlled substance analog or imitation controlled dangerous substance as defined in N.J.S.A. 2C:35-2 and N.J.S.A. 2C:35-11.

9. (No change in text.)

(b)-(f) (No change.)

10A:71-7.3 Motion for accelerated revocation

(a) (No change.)

(b) If the prosecuting authority or the Chief of the Bureau of Parole determines that the charges against the parolee are of a serious nature and the parolee otherwise poses a danger to public safety, the prosecuting authority or the Chief of the Bureau of Parole may apply in writing to the Chairperson or his or her designated representative for the prompt initiation of revocation proceedings. Such application shall include:

1.-4. (No change.)

(c) Upon review of the application and determination as to whether the charges against the parolee are of a serious nature and whether the parolee otherwise poses a danger to public safety, the Chairperson or his or her designated representative shall advise the prosecuting authority or the Chief of the Bureau of Parole and the District Parole Supervisor as to whether the revocation process shall be initiated.

(d)-(g) (No change.)

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# INSURANCE

## (b)

## DIVISION OF PROPERTY LIABILITY

### Commercial Lines Insurance: Prospective Low Cost Filing Procedures
### Adopted New Rules: N.J.A.C. 11:13-8

Proposed: March 15, 1993 at 25 N.J.R. 1047(a).

Adopted: July 26, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Filed: July 26, 1993 as R.1993 d.411, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1C-6(e), 17:1C-8.1 and 17:29AA-1 et seq.

Effective Date: August 16, 1993.

Expiration Date: November 10, 1997.

**Summary** of Public Comments and Agency Responses:

Two public comments were received from an insurance company (Wausau Insurance Companies) and an insurance rating organization (Insurance Services Office, Inc.). The Department also received one comment after the comment period due date.

COMMENT: One commenter expressed concern with N.J.A.C. 11:13-8.1, the purpose and scope section. The commenter believes that

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this section must comply and clarify that all the provisions of N.J.S.A. 17:29AA-1 et seq. and applicable provisions of N.J.A.C. 11:13 also apply to filings of prospective loss costs and loss cost multipliers.

RESPONSE: The Department disagrees with the commenter. This provision does not supersede any portion of N.J.S.A. 17:29AA-1 et seq. or the provisions of N.J.A.C. 11:13, but merely notes and cross references technical filing requirements in other rules. It is not necessary to amend this provision to provide any additional language as it relates to those particular provisions.

COMMENT: One commenter stated that N.J.A.C. 11:13-8.2, the definition section, should be revised. The commenter objected to the definition of "loss cost multiplier." The commenter believes that in the definition the term "adjustment" should replace the term "factor" since not all companies will apply multiplicative factors to the prospective loss costs. The commenter stated that an example of this would be a policy fee or an expense constant. The commenter also stated that the term "modifications" should replace the term "deviation" since the latter is terminology that has typically been used when referring to a rate environment.

RESPONSE: The Department agrees with the commenter's suggestions and has amended this section accordingly.

COMMENT: One commenter also objected to the definition used for the term "rate." The commenter stated that this definition should be expanded in order to clarify that the rate may be expressed as a single number or derived by combining a rating organization's prospective loss costs and an insurer's loss cost multiplier. The commenter believes that the Department should add language to this definition which states:

**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 and lost experiences.**

RESPONSE: The Department disagrees with the commenter. The definition of "rate" is the standard definition used by the Department as found in N.J.S.A. 17:29AA-3 and it is clear from that definition that expenses are permitted to be added.

COMMENT: One commenter stated that the definition of "rating organization" should be revised to correct a typographical error. The commenter noticed that the word "association" appears twice in the definition of "rating organization."

RESPONSE: The Department agrees with the commenter and therefore has amended this provision upon adoption.

COMMENT: One commenter objected to the definition of "supplementary rate information." The commenter stated that the current definition is a combination of the definition of N.J.S.A. 17:29AA-3(1) and the NAIC model. The commenter recommends that the statutory definition remain intact with additional language to further define supplementary rate information. This commenter suggested that this provision should read:

**"Supplementary Rate Information" includes 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, territorial 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.**

RESPONSE: After considering the definition as proposed, the commenter's suggestion and the statutory definition at N.J.S.A. 17:29AA-3(1), the Department has decided to use the statutory definition and has thus amended N.J.A.C. 11:13-8.2 upon adoption. The Department believes that the statutory definition is sufficiently broad to include all appropriate items. Providing a non-exclusive list may imply that items not listed are intentionally excluded.

COMMENT: One commenter stated that N.J.A.C. 11:13-8.3(b)1, the prospective loss cost filing requirements for rating organizations, should be amended. The commenter stated that it will be useful to clarify the statutory requirements which govern loss cost filings. The commenter believes that this provision should include a sentence at the end which states that "filings of prospective loss cost shall be filed and become effective in accordance with N.J.S.A 17:29AA-1 et seq."

RESPONSE: The Department disagrees with the commenter. The Department does not believe that it is necessary to include a reference to N.J.S.A. 17:29AA-1, because N.J.A.C. 11:13-8.3 does not supersede any portion of current laws established by the Department or any statutory provision.

COMMENT: Several commenters objected to N.J.A.C. 11:13-8.3 which requires rating organizations to print manuals of loss costs for all commercial lines of insurance. One commenter stated that for professional liability it will not print loss costs in the manual. The commenter stated that this decision is an economical one (that is, keep costs down) and is based on market research which shows no demand for loss costs in the manual for this line. The commenter further stated that insurers have historically used other methods for distributing rates for this line of insurance. The commenter also recommended that for clarity purposes the word "file" shall be inserted between "information" and "pursuant." The commenter suggested that this provision should be revised to read:

A rating organization [shall] **may** print and distribute manuals of prospective loss cost, as well as rules and other supplementary rating information **filed** pursuant to N.J.S.A. 17:29AA-1 et seq.

RESPONSE: The Department disagrees with the commenter. Printed manual pages are necessary in order for the Department to know what the rates are in effect for that particular line of coverage. The Department has amended this provision to require that a rating organization provide the Department with printed manuals of prospective loss cost, and rating organizations may print and distribute manuals of prospective loss costs upon request from member subscribers.

COMMENT: One commenter stated that the word "other" should be inserted before "supplementary" in order to clarify that the rules and relativities are in fact considered supplementary rating information. The commenter stated that this provision should be revised to read:

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

RESPONSE: The Department agrees in part with the commenter and has amended N.J.A.C. 11:13-8.3(d) to read: Rating organizations shall continue to develop and file supplementary rating information on behalf of their member/subscriber insurers.

COMMENT: One commenter stated that N.J.A.C. 11:13-8.4 should be revised to clarify the filing statutes that apply to the filing of loss costs multipliers. The commenter recommends that the Department add a sentence to this provision that provides that "an insurer's loss cost multiplier shall be filed and become effective in accordance with N.J.S.A. 17:29AA-1 et seq."

RESPONSE: The Department disagrees with the commenter and believes that this provision is redundant and not necessary.

COMMENT: One commenter stated that in N.J.A.C. 11:13-8.4(a)2i there is a typographical error that should be corrected. The commenter stated that this provision should state that "an insurer may file modifications to the rating organization's prospective loss cost filing based on [their] **its** own anticipated experience.

RESPONSE: The Department agrees with the commenter and has amended this provision accordingly.

COMMENT: One commenter expressed concern with N.J.A.C. 11:13-8.4(d). The commenter stated that it is confused as to the Department's intent with respect to the application of insurer's filed loss cost multiplier to subsequent revisions of the loss costs as made by the rating organization. The commenter questioned whether the phrase "which by its terms is applicable to subsequent rating organization prospective loss costs filings" means that:

(1) The insurer has the option to state in its filing letter that its multiplier will automatically apply to future revisions;

(2) The insurer can state in its filing letter that its multiplier will only apply to the current revision; or

(3) The Insurance Department is requiring that all multipliers, once filed, be automatically applicable to all future revisions unless the insurer files otherwise.

RESPONSE: The phrase "which by its terms is applicable to subsequent rating organization prospective loss cost filings" means that the Department is requiring that all multipliers, once filed, be automatically applicable to all future revisions unless the insurer states otherwise.

COMMENT: One commenter stated that N.J.A.C. 11:13-8.4(d) previously required the "final printed manual pages which will specify the lost (should be loss) cost multiplier and the effective date of its use" be submitted. The commenter stated that it is not clear what the Department expects to receive, whether it is a manual rule containing a loss cost multiplier and its rules of application or the loss cost pages from the rating organization's manual with the multiplier displayed on it. In addition, the commenter stated that it is unclear how this requirement relates to N.J.A.C. 11:3-8.4(d)1 which states that the insurer does not have to file anything. Additionally, the commenter stated that if it is the Department's intent to require that all multipliers filed by insurers

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be automatically applicable to subsequent revisions of prospective loss costs as filed by rating organization, and based on its understanding of current Department practices with respect to submission of final printed manual pages by insurers, the commenter recommends that this section be revised and reformatted as follows:

[An] **Once an** insurer [which has filed] **files** a loss cost multiplier with the Department, [which by its terms is] **such multiplier will be deemed to be automatically** applicable to subsequent rating organization prospective loss costs filings, [shall provide final printed manual pages which will specify the loss cost multiplier and the effective date of its use no later than 30 days after the effective date of the rate and shall adhere] **subject** to the following requirements:

(1) An insurer which intends to use [the] **a subsequent revision of** prospective loss cost and effective date as filed by the rating organization shall not file anything;

(2) An insurer which intends to use [the] a subsequent revision of prospective loss cost as filed but with a different effective date shall file with the Department its proposed effective date not more than 30 days after the effective date of the rating organization's prospective loss cost;

(3) An insurer which intends to use [the] **a subsequent** revision of the prospective loss costs and to change its loss costs multiplier [or deviations] shall file or revised Reference Filing Adoption Form not more than 30 days after the effective date of the rating organization's prospective loss cost reference filing; and

(4) An insurer which does not intend to use [the] **a subsequent** revision of the prospective loss cost shall notify the Department not more than 30 days after the effective date of the rating organization's prospective loss costs reference filing. The insurer shall file a Non-Adoption Prospective Loss Cost Form as set forth in Appendix B to this subchapter and incorporated herein by reference with the Department.

**(e) An insurer which has filed to adopt a rating organization's prospective loss cost shall 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 modification 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.**

RESPONSE: The Department agrees with the commenter and has amended this section accordingly.

COMMENT: One commenter stated that N.J.A.C. 11:13-8.5 describes the penalties that would apply for the failure to comply with the submission requirements. The commenter stated that this provision references N.J.S.A. 17:29AA-22 and 17:29AA-26. N.J.S.A. 17:29AA-26 specifies the general penalties, notice and hearing requirements and N.J.S.A. 29AA-22 pertains to the registration requirements for groups, associations or organizations engaged in joint underwriting or joint reinsurance and specifies the Commissioner's authority to regulate these entities. The commenter stated that these sections should be revised to delete the reference to N.J.S.A. 17:29AA-22 since it does not appear to be applicable to the issues addressed in these rules.

RESPONSE: The Department agrees with the commenter and has deleted this reference from the rule.

COMMENT: One commenter stated that on the referenced filing adoption form, line 14 should be titled "Company **Formula** Loss Cost Multiplier."

RESPONSE: The Department notes that its use of "Company Loss Cost Multiplier" is simply the name or label on the form for a particular number, which is already adequately described as the quotient of two other numbers on the form. The Department does not believe the suggested additional word adds anything to the label, and finds it unnecessary to revise the form where indicated (and elsewhere throughout the form and rule text).

COMMENT: One commenter suggested that a new line should be inserted after line 14, called "Company Selected Loss Cost Multiplier" to allow insurers to select a different multiplier. The commenter stated that one possible reason for doing this would be for rounding considerations. The commenter stated that such selection would then have to be supported or justified. The commenter stated that this is consistent with the option appearing on the Expense Constant Supplement.

RESPONSE: The Department disagrees with the commenter. The Department wants to receive and review the underlying information going into the insurer's loss cost.

COMMENT: One commenter suggested a revision to line 16. The commenter stated that the phrase "Note that for the initial loss cost filing, Item 15—1.000" is only correct to the extent that an insurer's deviation from previously filed ISO rates was based solely on expense or profit considerations. The commenter stated that since deviations from previous ISO rates may also have included some element of experience modification, this note should be eliminated to avoid the occurrence of incorrectly calculating rate level changes. The commenter recommended dropping the explanatory language in total, since insurers generally know how to calculate this amount.

RESPONSE: The Department disagrees with the commenter. The explanation is necessary to calculate the overall rate change. The Department has added a note to this section to provide additional clarification for insurers. The Department is adding language which states that:

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 Revised Loss Costs Level to Current Loss Costs Level.

COMMENT: One commenter suggested that on line 19 the word "prospective" should be replaced with the word "proposed."

RESPONSE: The Department believes the proposal uses the correct term.

COMMENT: One commenter suggested that on Form NA-1, Nonadoption of prospective loss cost, all references to "bureau" should be changed to "rating organiation," and all references to "bureau" designation number should be changed to "rating organization filing designation number."

RESPONSE: The Department agrees with the commenter and has amended this section accordingly.

COMMENT: One commenter noted that there is a similarity of these rules with other states' procedures with the exception of the completion of form NA-1, Adoption of Prospective Loss Costs. The commenter stated that other states just require a letter informing them of the insurer's intent.

RESPONSE: This form enables the Department to track what rates insurers are charging.

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

## SUBCHAPTER 8. COMMERCIAL LINES INSURANCE: PROSPECTIVE LOSS COSTS FILING PROCEDURES

### 11:13-8.1 Purpose and scope

(a) This subchapter establishes data requirements and procedures for member/subscriber insurers in rating organizations to adopt or modify a rating organization's filed 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 commercial lines insurance made pursuant to N.J.S.A. 17:29AA-1 et seq.

(c) All filings made pursuant to this subchapter shall be made in accordance with N.J.A.C. 11:1-32.

### 11:13-8.2 Definitions

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

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

"Department" means the New Jersey Department of 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 *[factor]* ***adjustment*** reflecting expenses, profit loading and any *[deviations]* ***modifications*** that the insurer uses on the loss cost 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

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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.

"Rating organization" means every person or persons, corporation, *[association,]* 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, *[policy fee, rate-related underwriting rule, experience rating plan]* and any other *[similar information needed to determine the applicable rate in effect or to be in effect]* ***rule used by an insurer in making rates***.

11:13-8.3 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; and

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

(c) A rating organization shall *[print and distribute]* ***provide the Department with printed*** manuals of loss costs, as well as rules and other supplementary rating information pursuant to N.J.S.A. 17:29AA-1 et seq.***, and may provide this information to its member/subscribers insurers upon request.***

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

11:13-8.4 Prospective loss costs filing requirements for insurers

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

1. Be a member/subscriber insurer in the rating organization; and

2. File its loss costs multiplier using the Reference Filing Adoption Form (as set forth in Appendix A to this subchapter and incorporated herein by reference). An insurer's final rates shall be a combination of the prospective loss costs and the loss costs multiplier set forth in its filed Reference Filing Adoption Form.

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

ii. An insurer's filed loss costs multiplier shall remain in effect until the insurer withdraws the multiplier or files a revised Reference Filing Adoption Form.

(b) Insurers may vary expense loads by individual lines, sublines or classifications of insurance. Insurers may use variable or fixed expense loads or a combination of these to establish their expense loadings.

1. An insurer's loss cost multiplier based on its expenses plus any profit provision shall not include the surtax or the Property-Liability Insurance Guaranty Association's assessments on private passenger automobiles pursuant to N.J.S.A. 17:30A-8a(9) and 17:33B-49.

2. Insurers shall provide documentation to support its profit loading.

(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. 29AA-13, or until the insurer makes a filing to change its rates, either by making an independent filing or by submitting a Reference Filing Adoption Form.

(d) *[An]* ***Once an*** insurer *[which]* has filed a loss costs multiplier with the Department, *[which by its terms is]* ***such multiplier shall be deemed to be automatically*** applicable to subsequent rating organizations prospective loss costs filings, *[shall provide final printed manual pages which will specify the lost cost multiplier and the effective date of its use no later than 30 days after the effective date of the rate and shall adhere,]* ***subject*** to the following requirements:

1. An insurer which intends to use *[the]* ***a subsequent revision of*** prospective loss cost and effective date as filed by the rating organization, shall not file anything;

2. An insurer which intends to use *[the]* prospective loss costs as filed but with a different effective date shall file with the Department its proposed effective date not more than 30 days after the effective date of the rating organization's prospective loss costs;

3. An insurer which intends to use *[the]* ***a subsequent*** revision of the prospective loss costs and to change its loss costs multiplier *[or deviations]*, shall file a revised Reference Filing Adoption Form not more than 30 days after the effective date of the rating organization's prospective loss costs reference filing; and

4. An insurer which does not intend to use *[the]* ***a subsequent*** revision of the prospective loss costs shall notify the Department not more than 30 days after the effective date of the rating organization's prospective loss costs reference filing. The insurer shall file a Non-Adoption of Prospective Lost Cost Form (as set forth in Appendix and incorporated herein by reference) with the Department.

***(e) An insurer which has filed to adopt a rating organization's prospective loss cost shall file with the Department, within 30 days of the effective date of the insurer's rates.***

***1. A final printed manual page indicating the loss cost modification 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.***

11:13-8.5 Penalties

Rating organizations and insurers which fail to comply with the filing submission requirements of this subchapter shall be subject to penalties pursuant to N.J.S.A. *[17:29AA-22 and]* 17:29AA-26.

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APPENDIX A

Date of filling out Form: _____

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***NEW JERSEY*** INSURER RATE FILING
ADOPTION OF ADVISORY ORGANIZATION
PROSPECTIVE LOSS COSTS
SUMMARY OF SUPPORTING INFORMATION 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 "SUMMARY OF SUPPORTING INFORMATION FORM"
(Use a separate Summary for each insurer–selected loss cost multiplier.)

****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 of Revised Loss Cost Level to Current Loss Cost Level.****

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Insurer Name: _____ Date of filling out Form: _____

NAIC #: Group:– Company:–

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

CALCULATION OF COMPANY LOSS COST MULTIPLIER

10. Line, Subline, Coverage, Territory, Class, etc. combination to which this page applies:

_____

11. Loss Cost Modification:
    A. The insurer hereby files to adopt the prospective loss costs in the captioned reference filing: (CHECK ONE)
    ☐ Without modification. (factor = 1.000)
    ☐ With the following modification(s). (Cite the nature and percent modification, and attach supporting data and/or rationale for the modification.)

    _____

    _____

    B. Loss Cost Modification Expressed as a Factor: _____
    (See examples below.)

NOTE: IF EXPENSE CONSTANTS ARE UTILIZED, ATTACH "EXPENSE CONSTANT SUPPLEMENT" OR OTHER SUPPORTING INFORMATION, AND DO NOT COMPLETE ITEMS 12–16 BELOW.

12. Development of Expected Loss Ratio. (Attach exhibit detailing insurer expense data and/or other supportir information.)

| | Selected Provisions |
|---|---|
| A. Total Production Expense | _____% |
| B. General Expense | _____% |
| C. Taxes, Licenses & Fees | _____% |
| D. Underwriting Profit & Contingencies | _____% |
| E. Other (explain) | _____% |
| F. TOTAL | _____% |

13A. Expected Loss Ratio: ELR = 100% – 12F = _____%
13B. ELR in decimal form = _____

14. Company Loss Cost Multiplier: (11B / 13B) = _____

15. Company Current Loss Cost Multiplier (only on subsequent Loss Cost Filings): _____

16. Rate level change for the coverages to which this page applies: _____%
    i.e. [(14/15) * Filed Loss Cost Level Change Factor] – 1.00 .
    (Note that for the initial Loss Cost Filing, Item 15 = 1.000).

Example 1: Loss Cost modification factor: If your company's loss cost modification is –10%, a factor of 0.9 (1.000 – .100) should be used.

Example 2: Loss Cost modification factor: If your company's loss cost modification is +15%, a factor of 1.15 (1.000 + .150) should be used.

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Insurer Name: _____ Date of filling out Form: _____

NAIC #: Group :– Company:–

***NEW JERSEY*** EXPENSE CONSTANT SUPPLEMENT

CALCULATION OF COMPANY LOSS COST MULTIPLIER

17. Development of Expected Loss Ratio. (Attach exhibit detailing insurer expense data and/or other supporting information.)

| | Selected Provisions | | |
|---|---|---|---|
| | Overall | Variable | Fixed |
| A. Total Production Expense | _____% | _____% | _____% |
| B. General Expense | _____% | _____% | _____% |
| C. Taxes, Licenses & Fees | _____% | _____% | _____% |
| D. Underwriting Profit & Contingencies | _____% | _____% | _____% |
| E. Other (explain) | _____% | _____% | _____% |
| F. TOTAL | _____% | _____% | _____% |

18 A. Expected Loss Ratio: ELR = 100%–Overall 17F = _____%

B. ELR expressed in decimal form = _____

C. Variable Expected Loss Ratio VELR = 100% – Variable 17F = _____%

D. VELR in decimal form = _____

19. Formula Expense Constant:

[(1.00 / 18B) – (1.00 / 18D)] * Average Proposed Loss Cost = _____

Formula Variable Loss Cost Multiplier: (11B / 18D) = _____

20. Selected Expense Constant = _____

Selected Variable Loss Cost Multiplier = _____

21. Rate level change for the coverages to which this page applies _____%

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APPENDIX B

***NEW JERSEY*** FORM NA–1

Non–Adoption of Prospective Loss Cost

1. Insurer: _____ NAIC #: _____

2. *[Bureau]* ***Rating Organization*** Affiliation: _____

3. Line of Insurance: _____

4. *[Bureau]* ***Rating Organization*** Designation Number: _____

5. Effective Date of Non–Adoption: _____

6. *[Bureau]* ***Rating Organization*** Designation Number Currently Being Used: _____

7. Effective Date of Use: _____

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# COMMERCE AND ECONOMIC DEVELOPMENT

## (a)

### URBAN ENTERPRISE ZONE AUTHORITY

### Urban Enterprise Zone Program and Business Certification

### Readoption with Amendments: N.J.A.C. 12A:120

Proposed: June 21, 1993 at 25 N.J.R. 2645(b).
Adopted: July 27, 1993 the Urban Enterprise Zone Aauthority, James N. Albers, Chairman Designate.
Filed: July 27, 1993 as R.1993 d.416, **without change**.
Authority: N.J.S.A. 52:27H-60 et seq., specifically 52:27H-65.
Effective Date: July 27, 1993, Readoption;
August 16, 1993, Amendments.
Expiration Date: July 27, 1998.

**Summary** of Public Comments and Agency Responses:
**No comments received.**

**Full text** of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 12A:120.

**Full text** of the adopted amendments follows:

12A:120-2.5 Alternative qualified small business recertification

(a) A qualified small business desiring to continue to receive zone business benefits may, upon agreement with the governing body of the qualifying municipality in which the enterprise zone is located and subject to the approval of the UEZA, agree to undertake investments in the enterprise zone in lieu of creating new employment. For purposes of this section, investments in the enterprise zone shall include, but shall not be limited to:

1. Improvements in the exterior appearance or customer facilities of the property constituting the place of business of the qualified business within the zone, provided that:

i. All improvements must be of a permanent nature;

ii. All improvements to the structure which are required to meet existing ordinances are not eligible;

iii. The qualified business submits at least one vendor's estimate of the project's costs with its "in-lieu" application; and

iv. Prior to the end of the current recertification year and upon completion of the improvement, a paid in full bill must be submitted to the UEZA and to the municipality;

2. Monetary or in-kind contributions to the qualifying municipality to undertake improvements to increase the safety or attractiveness of the zone to businesses which may wish to locate there or to consumer visitors to the zone, including but not limited to:

i.-vi. (No change.)

vii. Increase in police, fire or sanitation services in the enterprise zone;

3. Monetary contributions to the qualifying municipality to undertake employment related training programs; or

4. Monetary contributions to the qualifying municipality to undertake physical improvements or assist in educational or training programs of county schools, colleges and vocational schools.

(b) In order for an investment to constitute an alternative means by which a small business may become recertified as qualified zone business, the investment by that business shall:

1. (No change.)

2. If the business employs more than 10 employees, be not less than the amount produced by multiplying the number of employees employed by the small business by $500.00.

12A:120-2.11 Denial of recertification or conditional recertification of a qualified zone business

(a) When a business has been denied recertification or conditional recertification by failing to meet the requirements of a "qualified business," and by failing to increase permanent employment in the business, the business may appeal the Administrator's decision.

(b) (No change.)

12A:120-2.12 Procedure for appealing denial of recertification or conditional recertification

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

(d) The review will be conducted by a designee of the Commissioner. The designee shall issue a written report within 10 working days of the close of the review.

(e) The appealing business may request a hearing pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

# LAW AND PUBLIC SAFETY

## (b)

### DIVISION OF CONSUMER AFFAIRS
### STATE BOARD OF DENTISTRY

### Continuing Education

### Adopted New Rule: N.J.A.C. 13:30-8.18

Proposed: April 5, 1993 at 25 N.J.R. 1344(a).
Adopted: May 18, 1993 by State Board of Dentistry, Jerome Horowitz, D.D.S., President.
Filed: July 26, 1993 as R.1993 d.413, **without change**.
Authority: N.J.S.A. 45:6-10.1 to 10.9 and 45:6-19.4.
Effective Date: August 16, 1993.
Expiration Date: March 12, 1995.

**Summary** of Public Comments and Agency Responses:

The State Board of Dentistry afforded all interested parties an opportunity to comment on the proposd new rule, N.J.A.C. 13:30-8.18, relating to continuing education. The official comment period ended on May 5, 1993. Announcement of the opportunity to respond to the Board appeared in the New Jersey Register on April 5, 1993 at 25 N.J.R. 1344(a). Announcements were also forwarded to: Newark Star Ledger, Trenton Times, Asbury Park Press, Courier Post, Bergen Record, New Jersey Dental Association, New Jersey Hospital Association, New Jersey Dental Assistant Association, American Dental Hygiene Association, New Jersey Department of Health, and to other interested individuals and organizations.

A full record of this opportunity to be heard can be inspected by contacting the Board of Dentistry, 124 Halsey Street, Newark, New Jersey 07102.

The Board of Dentistry received 13 comments from interested parties during the official 30-day comment period.

Comments were received from the New Jersey Dental Association; the University of Medicine and Dentistry of New Jersey—Division of Continuing Dental Education; the New Jersey Academy of General Dentistry; Stephen T. Tafaro, D.M.D.; Spencer Z. Forman, D.M.D.; John A. Nunziato, D.D.S.; Leonard Karlin, D.D.S.; Warren Merguerian, D.D.S.; Video Dent, Inc.; Gerald S. Brooks, D.D.S.; Roger J. Szanto, D.M.D.; Eli Grossman, D.D.S.; and Philip J. Taverna, D.D.S.

Pursuant to N.J.S.A. 45:6-10.1 et seq., the New Jersey State Legislature has established mandatory continuing education requirements for dentists. Each applicant for a biennial license renewal will be required to complete a minimum of 40 credits of continuing dental education, except for the registration period commencing on November 1, 1993, for which 20 credits of continuing dental education will be required for the period July 1, 1992 to October 31, 1993. Although the law contains broad direction to licensees, the Legislature has delegated to the Board of Dentistry the authority to promulgate rules providing specific guidelines for the parameters for obtaining acceptable continuing education credit. Understandably, the Board has been inundated with inquiries from its licensees concerning their individual circumstances. Concerns in the profession have ranged from questions about whether a particular course or activity will be acceptable for credit, to questions about recordkeeping requirements and the method by which the Board will monitor compliance with the law. Since very little time remains until licensees will be required to have completed 20 hours of continuing education in order to register for the next biennial period, the Board determined that it was critical to promulgate guidelines as quickly as possible.

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Accordingly, although many of the comments received by the Board during the official comment period contained suggestions and recommendations which the Board deemed worthy of consideration, such items could not be incorporated in this rule immediately because they required further research and inquiry. Therefore, the new rule was adopted by the Board without change, and certain of these recommendations have been referred to the Board's Committee on Continuing Education for study. It is anticipated that the recommendations of the Committee to the Board will be made so that any amendments to the current rule can be proposed at the outset of the next renewal period commencing November 1, 1993. The following recommendations received from commentors will be under consideration:

1. The inclusion of home study as an acceptable vehicle for continuing education credit by way of videotape, audiotape, and/or correspondence courses;
2. Specific inclusion of the program portion of component dental society meetings for credit when the topic concerns the practice of dentistry;
3. Requiring licensees to maintain continuing education records for two biennial periods or four years rather than the seven years required in the current rule;
4. Allowing two credits of continuing education for licensees who hold teaching positions for one-half day per week. The current rule contains a provision for four credits for licensees who teach one day per week;
5. Allowing additional hours of credit for advanced courses and/or instruction of Cardio-Pulmonary Resuscitation (CPR) and related life support courses;
6. Allowing a specified number of credits for practice management courses;
7. Allowing continuing education credit for medical topics and other health care courses as they relate to dentistry;
8. Provision of specific guidelines in the rule for pre-approval of continuing education sponsors since the rule is specific in regard to the pre-approval of continuing education programs;
9. Allowing a specified number of credits for the out-of-class clinical portion of Protocol Participation Courses;
10. Allowing continuing education credit to a licensee who takes a specialty board certification examination during a renewal period; and
11. Allowing continuing education credit for licensees who take courses or are instructors for Emergency Medical Technician (EMT) programs.

A summary of the comments received and the Board's responses follows:

COMMENT: It is recommended that the Board recognize and accept existing national sponsor approval programs of the American Dental Association (Continuing Education Recognition Program, CERP) and the Academy of General Dentistry (National Sponsor Approval Program, NSAP) for the purpose of approving organizations which are major sponsors of continuing education.

RESPONSE: The Board has reviewed the standards and criteria which must be met by sponsors of continuing education before they are approved by the CERP program and the NSAP program. The Board agrees that the standards are rigorous and will accept those sponsors who have been approved by these programs. However, the CERP program is not expected to be operational until fall 1993. In addition, although the Board will recognize sponsors approved by these programs, that does not mean that every continuing education program offered by these sponsors will be approved unless it otherwise falls within the parameters set forth in the new rule.

COMMENT: It is recommended that the Board waive continuing education requirements for new licensees who will be renewing their biennial registration for the first time in October 1993.

RESPONSE: The law does not authorize the Board to waive continuing education requirements for those licensees who are renewing their license for the first time. However, the Board may, in its discretion, waive requirements upon a proper written application and on an individual basis for reasons of hardship which the Board would deem to include extenuating circumstances causing extraordinary financial hardship.

COMMENT: Licensees should be permitted to carry over continuing education credits in excess of the requirement to the next biennial period.

RESPONSE: The Board considered this issue at length during the course of developing the rule. The Board determined to disallow carry-over credit on the basis that it wanted to be sure that each licensee completed at least 40 hours of continuing education credit during each biennial period.

COMMENT: It is recommended that rather than requiring "successful completion" of a course that the Board change the language to requiring "attendance and/or other criteria required by the sponsor" of the course.

RESPONSE: Although the Board does not see a significant difference between the two phrases, this is another issue which the Board's Committee on Continuing Education may review in the future. For the time being, however, successful completion of a course will be deemed to include attendance as well as completion of other criteria required by the sponsor.

**Full text** of the adoption follows:

13:30-8.18 Continuing dental education

(a) No renewal certificate of registration shall be issued by the Board of Dentistry for the biennial period commencing November 1, 1993 or any following year until the applicant certifies as part of the application for renewal of the certificate of registration that he or she has completed courses of continuing professional dental education of the types and number of credits specified in this section. Such continuing education shall be a mandatory requirement for license renewal, except that the Board shall not require completion of continuing dental education credits for initial registration of dentists.

(b) Each applicant for a biennial license renewal shall be required to complete, during the preceding biennial period, a minimum of 40 credits of continuing dental education, except for the registration period commencing on November 1, 1993, for which 20 credits of continuing dental education shall be required for the period July 1, 1992 to October 31, 1993. Any applicant who is initially licensed subsequent to the commencement of any biennial registration period shall be required to complete dental education credits on a pro rata basis prior to the next renewal period.

(c) One hour of continuing education credit shall be granted for each hour of instruction at lectures, seminars, clinical or laboratory participatory courses, or other educational methods as may be approved by the Board, excluding time spent at meals, breaks or business sessions. Credit shall be granted only for full instructional hours, but not for less than one instructional hour. Successful completion of an entire course or segment of course instruction is required in order to receive any continuing education credit. Unless otherwise provided, only in-class participation, not student time devoted to preparation, will be counted.

(d) It shall be the responsibility of each licensee to maintain an authenticated record of all continuing education activity completed and to be prepared to submit evidence of completion of the credit requirements to the Board upon request. Each licensee must obtain from the continuing education course sponsor and retain for a period of seven years an authenticated record of attendance which shall include, at a minimum, the following:

1. The participant's name;
2. The title or subject area of the course;
3. The instructor;
4. The course sponsor;
5. The date and location of the course;
6. The number of hours; and
7. Verification of successful completion by the course sponsor.

(e) The Board shall monitor compliance with the mandatory continuing dental education requirement by requesting some licensees, at the discretion of the Board, to provide documentary proof of successful completion of continuing education credits.

(f) All continuing education activities to be accepted for credit shall have significant intellectual or practical content which deals primarily with matters directly related to the practice of dentistry or with the professional responsibilities or ethical obligations of licensees. Subjects such as estate planning, financial or investment/tax planning, personal health or others so deemed by the Board from time to time shall not be acceptable for continuing education credit. In addition, correspondence programs and other individual study programs, including taped or video study programs, shall not be acceptable for continuing education credit.

(g) The Board shall maintain a list of approved course sponsors and accredited education programs and shall make this list available to licensees upon request.

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(h) A continuing education sponsor may receive prior approval for a course of acceptable subject matter and be assigned a designated number of continuing education credits by the Board if the program sponsor provides, in writing and on a form provided by the Board, information required by the Board to document that the sponsor offers courses which meet the following requirements:

1. The course is offered in a subject matter and in a format permissible pursuant to the provisions of this section;

2. The course is conducted by a qualified instructor or discussion leader; and

3. The course is at least one hour in length.

(i) Prior approval of a continuing education sponsor and/or program and the continuing education credit allowed for the program shall be renewed every two years and at such other times as the program is to be altered substantially. Applications for pre-approval of continuing education programs must be submitted by the program sponsor on the form provided by the Board at least 45 days prior to the date the continuing education program is to be offered. Incomplete applications shall be returned to the sponsor and may result in a failure to grant prior approval of the program. Although failure to obtain prior approval shall not preclude acceptance of the program, there shall be no assurance that the Board will grant approval retroactively.

(j) A licensee may select from any of the areas of study listed below, except that for purposes of obtaining continuing education credits towards the mandatory requirement the licensee may not exceed the maximum number of hours permitted in each category.

1. Educational and scientific courses:

i. A licensee may obtain all of the required continuing education hours in this category. Educational and scientific courses must be offered by approved sponsors or granted prior approval by the Board in accordance with the procedure provided herein.

ii. Completion of an accredited one year dental residency program or completion of an approved advanced education program leading to specialty certification in endodontics, oral surgery, oral pathology, orthodontics, pediatric dentistry, periodontics, prosthodontics, or public health shall satisfy the entire requirement of continuing education hours for one biennial registration period.

iii. A maximum of five hours of continuing education shall be given for basic C.P.R. courses.

2. Papers, publications and scientific presentations:

i. A licensee may obtain a maximum of 20 hours of continuing education credit in this category.

ii. A maximum of 10 hours of continuing education credit shall be given for each original scientific paper authored by the licensee and published in a refereed journal. At the discretion of the Board, these 10 hours may be divided among all co-authors.

iii. For each original presentation of a paper, essay or formal lecture to a recognized group of fellow professionals, the presentor shall receive two hours of continuing education credit for every hour of presentation.

3. Teaching and research appointments:

i. A licensee may obtain a maximum of 10 continuing education credit hours in this category.

ii. A licensee involved in teaching or research activities at least one full day per week per academic year and who holds at least a part time faculty or research appointment shall receive four hours of continuing education credit annually for each full day.

4. Table clinics and scientific exhibits:

i. A licensee may obtain a maximum of eight continuing education hours in this category.

ii. The original presentation of a table clinic or scientific exhibit at a professional meeting will provide a maximum of one hour of continuing education credit per clinic or exhibit for each two hours of presentation.

(k) Those licensees who complete 20 hours of continuing education credit in accordance with the requirements for parenteral conscious sedation and/or general anesthesia permit holders pursuant to N.J.A.C. 13:30-8.2 and 8.3 shall be given credit for all 20 hours towards fulfilling the general requirement for professional continuing education under this section so long as the credits otherwise comply with the provisions of this section.

(l) Every licensee shall be required to obtain three hours of the mandatory continuing education credits during each biennial registration period in the area of basic infection control procedures.

(m) Any continuing education credits which are completed by a licensee in excess of the requirement as provided in this section shall not be credited to any subsequent registration period.

(n) Any continuing education courses directed or ordered by the Board as a remedial or punitive measure shall not be eligible to fulfill the general mandatory continuing education requirement.

(o) The Board may, in its discretion, waive requirements for continuing dental education on an individual basis for reasons of hardship such as illness or disability, retirement of the licensee, or other good cause including, but not limited to, a full time faculty appointment to an accredited dental school or dental hygiene school or inactive licensees who are practicing outside of the State. Any licensee seeking a waiver of the continuing education requirement must apply to the Board in writing and set forth with specificity the reasons for requesting the waiver. The licensee also shall provide the Board with such additional information as it may reasonably request in support of the application. In cases of illness, disability, retirement, practice outside of the State, or other good reason, the licensee shall be placed on inactive or retirement status and shall be prohibited from engaging in the practice of dentistry in the State of New Jersey unless and until such licensee is reinstated with a current active registration. In addition, the Board may, in its discretion, require the completion of continuing education requirements as a condition for reinstatement of active licensure.

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## (a)

## DIVISION OF CONSUMER AFFAIRS
## STATE BOARD OF PHARMACY

### Fees

### Adopted Amendment: N.J.A.C. 13:39-1.3

Proposed: April 19, 1993 at 25 N.J.R. 1666(a).

Adopted: July 14, 1993 by the State Board of Pharmacy, Edith Tortora Micale, President.

Filed: July 26, 1993 as R.1993 d.414, **without change.**

Authority: N.J.S.A. 45:14-26.2 and 45:1-3.2.

Effective Date: August 16, 1993.

Expiration Date: June 19, 1994.

The State Board of Pharmacy afforded all interested parties an opportunity to comment on the amendment to the Board's fee schedule, N.J.A.C. 13:39-1.3, as proposed in the New Jersey Register on April 19, 1993 at 25 N.J.R. 1666(a). The official comment period ended on May 19, 1993. Announcements of the opportunity to respond to the Board were also forwarded to the Star Ledger, the Trenton Times, the National Wholesale Druggists Association, the New Jersey Department of Health, Drug Store News, the Essex County Pharmaceutical Association, the Bergen County Pharmacy Society and to other interested parties.

A full record of this opportunity to be heard can be inspected by contacting the State Board of Pharmacy, Post Office Box 45013, Newark, New Jersey 07101.

**Summary** of Public Comments and Agency Responses:

During the 30-day comment period, the Board received four responses to the proposal. On April 21, Leon R. Langley, Director of Government Affairs, New Jersey Pharmaceutical Association (the Association) requested budget information for use in developing comments on the proposal. In response, the Board requested the Division to develop a document which would provide useful information upon which the Association could base its remarks and mailed that information to the Association on May 13, 1993. On May 14, prior to its receipt of the information, the Association asked for a 30-day extension of the comment period so that it could receive and evaluate the requested information. Because the information had been forwarded to the commenter, the Board determined not to extend the comment period. The Association made no further submissions to the Board based upon the budgetary information supplied to it either prior or subsequent to the close of the comment period.

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Summarized below are the comments made in the Association's May 14 letter as well as the comments of the other three commenters, all Board licensees, who responded to the proposal during the 30-day comment period. These commenters were Mark J. Kana, Director of Pharmacy, the Hospital Center at Orange; Barbara Schneider; and Richard S. Turse.

COMMENT: Referring to the statement in the proposal that licensing fees have not been raised in over 10 years, the Association asked which of those years the Board was "in the black" and which years the Board was "in the red, if any." The Association objected to the "extremely heavy and perhaps unwarranted" fee increases and stated that contrary to the Economic Impact statement the increases may have an adverse economic impact on some licensed individuals and businesses.

RESPONSE: The Board has a statutory obligation to meet its operating costs and has always done so. As stated in the proposal, N.J.S.A. 45:1-3.2 requires all boards within the scope of Subtitle 1 of Title 45 to be self funding; that is, operating costs must be met through licensing and other fees. In past years, the receipt of fines has added to the Board's budget, enabling the biennial registration fees to be maintained at a consistent level. However, for the reasons more specifically set forth below, unless an overall fee increase is implemented at this time, the Board will not have sufficient funds to enable it to continue to meet its statutory obligation to protect the public health, safety and welfare.

The need for substantial additional revenues at this time is based upon lengthy Board consideration of the following significant concerns. First, the Board's investigative staff has been at about half that necessary to address the number of consumer complaints received, resulting in a backlog of complaints which has been increasing at a steady rate over the years. In order to properly protect the public, therefore, the budget reflects an increase in investigative staff assigned to the Board. The Board believes the assignment of these additional investigators will bring the staff to an acceptable level. Second, the Board has been reviewing continuing education (CE) programs free of charge. This review and approval process requires a substantial amount of Board as well as administrative staff time and expense, reimbursement for which has placed a drain on the Board's operating budget. In order to solve this problem and in line with Division policy to allocate fees for the specific services provided, the new fee schedule includes CE review fees which will be paid by those individual licensees and program providers seeking such review. Placing the economic burden upon the user of services will remove the burden from the licensee class as a whole.

The Division and the Board are confident that the revenues to be generated by the fee increases are both reasonable and necessary to enable the Board to continue to protect the public and to maintain the integrity of the profession. While the Board recognizes and is sensitive to the adverse impact of rising costs on individuals and businesses, particularly in light of the current uncertain economic climate, it believes the increase of approximately $27.00 per year for pharmacists and $90.00 per year for pharmacies is not unduly burdensome, especially when weighed against the considerable benefit which is likely to accrue to the public as the result of the significant increase in the Board's investigative staff.

The Board also points out that the budget review process is ongoing during the biennial period. In the unlikely event excess funds are raised during the upcoming biennial renewal period, they will be carried over to the next renewal period for the benefit of the Board.

COMMENT: Fee increases should be implemented incrementally over a three-year period.

RESPONSE: This cannot be accomplished for two reasons. First, the licensing fees must be collected at the outset of the renewal period since they are needed to cover current and ongoing operating expenses. Second, with only one exception all of the Division's licensing boards operate on a biennial cycle and fees are collected by the Central Licensing Bureau. To institute a separate system for this Board would not be administratively or economically efficient and would work to the detriment of the Board.

COMMENT: How does the $140.00 biennial registration fee compare to other states' registration fees?

RESPONSE: The Board does not have specific information as to the biennial registration fees of other states. However, because the fee structure of New Jersey's professional and occupational licensing boards is mandated by statute, N.J.S.A. 45:1-3.2, it cannot be based upon considerations such as other states' biennial registration fees. Rather, it is structured so as to provide sufficient funds to cover, but not exceed, the Board's operating costs.

COMMENT: How, when and upon whom will the $10.00 continuing education review fee and the $50.00 program provider review fee be imposed?

RESPONSE: The $10.00 review fee is paid by a licensee who requests Board review of a continuing education course attended by the licensee which has not yet been granted Board approval in order to determine whether the Board will grant CE credit. Similarly, the $50.00 program provider review fee is paid by a CE provider and is intended to cover the Board's administrative costs of course review and approval.

COMMENT: If the $50.00 fee is to be levied on a program provider for each new program reviewed, it may discourage the availability of CE programs, particularly hospital-based programs offered on a one-time basis.

RESPONSE: As stated in the proposal, the Division of Consumer Affairs has endeavored to establish fees for all professional boards which will specifically identify the actual elements for which a board incurs expenses. The Board believes that $50.00 is a fair fee for the work involved in reviewing CE programs on an individual basis and issuing Board approval and that it will not discourage providers of high quality CE programs from offering those programs.

COMMENT: The $60.00 yearly fee for distribution of minutes and agenda could discourage access to important information and input to the Board. The commenter asked who will pay this fee and whether certain individuals and/or organizations are exempt.

RESPONSE: Again, in keeping with the overall Division policy of allocating fees for the specific Board services provided, the $60.00 fee is intended to cover copying and mailing costs. In the Board's opinion, this minimal amount—which translates into $5.00 per month—will not discourage those interested in gaining information from or providing input to the Board on a regular basis.

**Full text** of the adoption follows:

13:39-1.3 Fee schedule

(a) The following fees shall be charged by the Board:

1. For pharmacists as follows:

i. Application for registration $125.00.

ii. Examination: $50.00 plus the cost of the National Association of Boards of Pharmacy Licensing Examination (NABPLEX).

(1) Law examination 60.00.

iii. Reciprocal fee 125.00.

iv. Reinstatement of licensure: 225.00 plus application fee.

v. Initial registration fee:

(1) If paid during the first year of a biennial renewal period: 140.00.

(2) If paid during the second year of a biennial renewal period: 70.00.

vi. Biennial registration 140.00.

vii. Replacement registration certificate 25.00.

viii. Transfer of grades: 125.00.

ix. Late renewal fee: 100.00.

x. Replacement wall certificate: 40.00.

xi. Continuing education review fee: 10.00.

xii. Continuing education program: provider review fee: 50.00.

xiii. Yearly fee for distribution of minutes and agenda: 60.00.

2. For pharmacies as follows:

i. Pharmacy permits:

(1) Application for permit 275.00.

(2) Annual renewal: 175.00.

(3) Change of ownership: 275.00.

(4) Change of location 275.00.

ii. Replacement permit certificate 25.00.

iii. Replacement wall permit: 25.00.

iv. Late renewal fee: 100.00.

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# TRANSPORTATION

## (a)

### DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

### BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

### Speed Limits

### Routes N.J. 167 in Atlantic County and N.J. 44 in Gloucester County

### Adopted Amendment: N.J.A.C. 16:28-1.93.

### Adopted New Rule: N.J.A.C. 16:28-1.48.

Proposed: June 7, 1993 at 25 N.J.R. 2225(a).
Adopted: July 9, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: July 16, 1993 as R.1993 d.400, **without change**.

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-98.

Effective Date: August 16, 1993.
Expiration Date: May 7, 1998.

**Summary** of Public Comments and Agency Responses:
**No comments received.**

**Full text** of the adoption follows:

16:28-1.48 Route 167
(a) The rate of speed designated for the certain parts of State highway Route N.J. 167 described in this subsection shall be established and adopted as the maximum legal rate of speed:
1. For both directions of traffic:
i. In the City of Port Republic, Atlantic County:
(A) 25 miles per hour for the entire length (approximate mileposts 0.00 to 0.62).

16:28-1.93 Route 44
(a) The rate of speed designated for the certain parts of State highway Route N.J. 44 described in this subsection shall be established and adopted as the maximum legal rate of speed:
1. For both directions of traffic in Gloucester County:
i. (No change.)
ii. Greenwich Township:
(1) Zone 1: 50 miles per hour between the Logan Township northerly line and 2525 feet North of Repaupo Creek (approximate mileposts 2.14 to 2.60); thence
(2) Zone 2: 40 miles per hour between 2525 feet south of Repaupo Creek and 50 feet south of Willow Drive (approximate mileposts 2.60 to 3.00); thence
(3) Zone 3: 35 miles per hour between 50 feet south of Willow Drive and the Borough of Paulsboro southwesterly line (Billingsport Road), except for 25 miles per hour when passing through the Gibbstown Elementary School zone (mileposts 3.51 to 3.74) during recess when the presence of children is clearly visible from the roadway or while children are going to or leaving school, during opening or closing hours (approximate mileposts 3.00 to 5.18); thence
iii. (No change.)
iv. West Deptford Township:
(1)-(2) (No change.)
(3) Zone 3: 40 miles per hour between 800 feet south of Church Street and Route I-295-Route U.S. 130 (approximate mileposts 8.37 to 9.60).
2.-3. (No change.)

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## (b)

### DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

### BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

### Restricted Parking and Stopping

### Routes U.S. 1 Business in Mercer County; U.S. 9 in Ocean and Monmouth Counties; N.J. 26 in Middlesex County; N.J. 33 in Middlesex County; U.S. 46 in Warren and Morris Counties; and N.J. 57 in Warren County

### Adopted Amendments: N.J.A.C. 16:28A-1.1, 1.7, 1.17, 1.23, 1.32 and 1.36

Proposed: June 7, 1993 at 25 N.J.R. 2226(a).
Adopted: July 9, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: July 16, 1993 as R.1993 d.401, **with a technical change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.

Effective Date: August 16, 1993.
Expiration Date: May 7, 1998.

**Summary** of Public Comments and Agency Responses:
**No comments received.**

**Full text** of the adoption follows (addition to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks *[thus]*):

16:28A-1.1 Route U.S. 1 Business
(a) (No change.)
(b) The certain parts of State highway Route U.S. 1 Business described in this subsection shall be designated and established as "no parking bus stop" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:
1.-2. (No change.)
3. Along the northbound (easterly) side in Mercer County:
i. In Lawrence Township:
(1) Near side bus stop:
(A) Colonial Lake Drive—Beginning at a point 35 feet south of the southerly curb line of Colonial Lake Drive and extending 70 feet southerly therefrom.

16:28A-1.7 Route U.S. 9
(a) (No change.)
(b) The certain parts of State highway Route U.S. 9 described in this subsection shall be designated and established as "no parking bus stop" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:
1.-4. (No change.)
5. Along the easterly (northbound) side in Marlboro Township, Monmouth County:
i.-ii. (No change.)
iii. Far side bus stop:
(1) Station 452 U turn between Covered Bridge Boulevard and Union Hill Road—Beginning 68 feet from the northerly curb line of Station 452 and extending 140 feet north therefrom.
6. Along the westerly (southbound) side in Marlboro Township, Monmouth County:
i. Far side bus stops:
(1)-(2) (No change.)

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(3) Station 452 U-turn between Covered Bridge Boulevard and Union Hill Road—Beginning at the southerly curb line of Station 452 and extending 135 feet south therefrom.

ii. (No change.)

7.-40. (No change.)

(c) (No change.)

16:28A-1.17 Route 26

(a) The certain parts of State highway Route 26 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs will be erected.

1. No stopping or standing in North Brunswick Township, Middlesex County:

i.-ii. (No change.)

iii. Along both sides:

(1) From Route U.S. 1 (northbound) to Patton Street.

(2) From Route U.S. 1 to McCaulliffe Drive—York Road.

16:28A-1.23 Route 33

(a) The certain parts of State Highway Route 33 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs will be erected.

1.-7. (No change.)

8. No stopping or standing in Monroe Township, Middlesex County:

i. Along both sides:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30.

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

16:28A-1.32 Route U.S. 46

(a) The certain parts of State highway Route U.S. 46 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs will be erected.

1.-18. (No change.)

19. No stopping or standing in Independence Township, Warren County:

i. Along both sides:

(1) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30.

(b) The certain parts of State highway Route U.S. 46 described in this subsection shall be designated and established as "no parking bus stop" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1.-14. (No change.)

15. Within Montville Township, Morris County:

i. Along the westbound (northerly) side:

(1) Mid-block bus stop:

(A) Change Bridge Road—Beginning at a point 246 feet west of the westerly curb line of Change Bridge Road and extending 135 feet westerly therefrom.

16:28A-1.36 Route 57

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

***[(e)]**(d)*** The certain parts of State highway Route 57 described in this subsection shall be designated and established as "time limit parking" zones where parking is prohibited except as specified. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established time limit parking zones:

1. In Washington Borough, Warren County:

i. Along both sides (Washington Avenue):

(1) Two hours time limit parking from 8:00 A.M. to 6:00 P.M. daily from Belvidere Avenue and Broad Street to Jackson Avenue.

(2) Two hours time limit parking daily from 8:00 A.M. to 6:00 P.M. from Belvidere Avenue and Broad Street to Lincoln Avenue.

# OTHER AGENCIES

## (a)

## CASINO CONTROL COMMISSION

### General Provisions

### Organization and Operation of the Commission

### Adopted Amendments: N.J.A.C. 19:40-2.1

Adopted: July 21, 1993 by Casino Control Commission, Steven P. Perskie, Chairman.

Filed: July 23, 1993 as R.1993 d.404.

Authority: N.J.S.A. 5:12-69(a) and 52:14B-4(b).

Effective Date: July 23, 1993.

Expiration Date: August 24, 1994.

These proposed amendments are organizational and, as such, in accordance with N.J.S.A. 52:14B-4(b) may be adopted without prior notice or hearing and are effective upon filing.

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

19:40-2.1 Organization

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

(c) The Commission's staff shall be comprised of the divisions **and offices** set forth below. Each division **and office** shall be organized into such operational units, and each unit shall have such assigned positions, as the Chair shall direct.

1. The [Division of Administration] **Office of Administrative Services** shall provide the personnel, budget, data processing and administrative services necessary for the operation of the Commission; maintain the official records of the Commission and a record of all Commission proceedings; and serve as the central filing location for petitions and submissions submitted to the Commission.

2.-4. (No change.)

5. The Office of the Commissioners shall consist of the Affirmative Action Officer, the General Counsel, the Public Information Officer, the Director of Governmental and Community Relations, **the Director of Organizational Development** and the Executive Secretary, together with the members of their respective staffs. The members of the office, together with the Chair, the directors of the several divisions and such members of the senior staff as the Chief of Staff may designate shall constitute the management team of the Commission, and shall execute general Commission policies as established by the Commission.

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## (a)

## CASINO CONTROL COMMISSION

### Rules of the Games
### Pokette
### Payout Odds
### Adopted Amendment: N.J.A.C. 19:47-12.6

Proposed: May 17, 1993 at 25 N.J.R. 1962(a).
Adopted: July 21, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: July 23, 1993 as R.1993 d.405, **without change**.
Authority: N.J.S.A. 5:12-63(c), 70(f), 99(a) and 100(e).
Effective Date: August 16, 1993.
Expiration Date: April 15, 1996.

**Summary** of Public Comment and Agency Response:
COMMENT: The Division of Gaming Enforcement supports the proposed amendment, as published.
RESPONSE: Accepted.

**Full text** of the adoption follows:

19:47-12.6 Payout odds
(a) (No change.)
(b) Each casino licensee shall pay off winning wagers at the game of pokette at no less than the odds listed below:

| Wager | Payout Odds |
|---|---|
| Single card straight up | 50 to 1 |
| Two cards or split bet | 24 to 1 |

. . .

## (b)

## CASINO CONTROL COMMISSION

### Equal Employment and Business Opportunity
### Adopted Repeal and New Rules: N.J.A.C. 19:53

Proposed: April 19, 1993 at 25 N.J.R. 1675(a).
Adopted: July 21, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: July 23, 1993 as R.1993 d.406, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).
Authority: N.J.S.A. 5:12-63, 69, 75, 134 and 135.
Effective Date: August 16, 1993.
Expiration Date: December 15, 1995.

**Summary** of Public Comments and Agency Responses:
A public hearing regarding the proposed repeal and new rule was held on May 7, 1993, at the Commission's Atlantic City offices. The hearing was conducted by the full Commission. No specific recommendations were made other than to adopt the proposed repeal and new rule, with technical and minor substantive changes, and to propose additional amendments for the reasons stated below. The proposed amendments to the adopted new rule may be found in the "Proposals" section of this Register. Interested parties can review a transcript of the Commission hearing and all written statements submitted in response to the proposal at the Casino Control Commission office located at Tennessee Avenue and the Boardwalk, Atlantic City, New Jersey.

Oral comments were presented at the hearing by 18 organizations or individuals. Ten of the commenters supplemented their oral presentations through the submission of written statements which were incorporated into the hearing record. The commenters at the hearing, and those submitting written statements, were as follows: the South Jersey Chapter of the National Business League (National Business League) (statement); the Casino Association of New Jersey (CANJ) (statement); the Newark Minority Business Development Center (Newark MBDC) (statement); the Black Issues Convention; the Tallahassee Neighborhood Trust; Mr. Joe Brown; the Community Health Law Project (statement); the New Jersey Developmental Disabilities Council (DDC) (statement); Handicapped Advocates for Independent Living (HAIL); the ARC of New Jersey (the ARC) (statement); the New Jersey Public Advocate (statement); the Rutgers University Bureau of Economic Research, Disability and Health Economics Section (Bureau of Economic Research) (statement); the New Jersey Association for Persons in Supportive Employment (APSE); the Hispanic Alliance of Atlantic County (Hispanic Alliance); Promatech, Inc. (statement); the General Baptist Convention; the Mercer County Office of Small/Minority Business (Mercer County OSMB) (statement), and the Allen A.M.E. Church. In addition, written statements were received from the New Jersey and Atlantic City Chapters of the NAACP (NAACP) and from Mr. David Delaney; these statements were included in the record of the public hearing.

Written comments submitted in response to the proposal were received from: Franklin Electric Company; the Division of Gaming Enforcement (DGE); Middleton Development Corporation; the Atlantic City Fellowship of Churches (Fellowship of Churches); the Morris County Human Relations Commission (Morris County HRC), and the Eastern Paralyzed Veterans Association (EPVA).

COMMENT: The National Business League, the Newark MBDC, the Black Issues Convention, the General Baptist Convention, the Mercer County OSMB, the Allen A.M.E. Church, the NAACP and the DGE all expressed general support for the adoption of the new rules.

RESPONSE: The Commission accepts the comments as evidenced by its adoption of the new rules.

COMMENT: The National Business League, CANJ and the DGE suggested that an acronym other than EEBOP should be used to identify the equal employment and business opportunity plan required of casino licensees and applicants pursuant to the new rules.

RESPONSE: The Commission believes that the acronym EEBOP readily and accurately identifies the subject matter of the required equal employment and business opportunity plan and that the serious tenor of the rules and the Commission's interest in accomplishing meaningful enforcement thereof is not diminished in any way by the use of this acronym.

COMMENT: The National Business League expressed concern about combining the goals of equal employment opportunity and business development in a single plan. According to the commenter, the regulatory emphasis needed to accomplish each of these goals is different: equal employment opportunity requires full implementation of existing law, while business development requires a spirit of cooperation which should not get bogged down in bookkeeping.

RESPONSE: The Commission disagrees with the comment to the extent that the comment implies that the goals of equal employment and business opportunity are somehow divergent. Certainly, the accomplishment of each of these goals will depend, in part, on different regulatory mechanisms and requirements. But neither of these goals will be obtained unless all parties involved adopt an attitude of cooperation and dedicate themselves to the establishment of real equal opportunity in the casino industry, whether in the context of employment or business development.

COMMENT: CANJ commented favorably on the process of interaction and cooperation among all segments of the community, industry and regulatory agencies in developing the rules and noted that this interaction and cooperation will have to continue if the objectives of the rules are to be achieved.

RESPONSE: The Commission agrees with the comment of CANJ.

COMMENT: The Hispanic Alliance expressed the opinion that the Affirmative Action/Equal Employment Opportunity Unit of the Commission is understaffed and should report directly to the Chairman of the Commission.

RESPONSE: Although the comment is not responsive to the regulatory proposal, the Commission believes it is in the best position to judge its method of organization and the appropriate distribution of its staff resources. The Commission's AA/EEO Unit is more than capable of handling its responsibility to oversee the implementation of the new chapter of equal employment and business opportunity rules. Should adjustments be required in the future, the Commission will act at the appropriate time and in the appropriate manner.

COMMENT: The DGE suggested that the definition of minority contained in N.J.A.C. 19:53-1.2 be conformed with the definition of that term used by the U.S. Equal Employment Opportunities Commission (EEOC).

RESPONSE: The definition of minority used by the Commission is derived from the definition of minority contained in the Uniform Certifications Act, N.J.S.A. 52:27H-21.11, the New Jersey statute

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pursuant to which all certifications of minority and women enterprises which deal with State agencies are supposed to occur. The Commission maintains that this definition is a more appropriate source of guidance for its rules than the rules of the EEOC.

COMMENT: The DGE suggested that N.J.A.C. 19:53-2.1(e) and 6.7(a) be reworded for purposes of clarification.

RESPONSE: The Commission agrees with the DGE and included the suggested changes in the rules at adoption, replacing "the earlier of" with "whichever occurs first."

COMMENT: The Fellowship of Churches requested that a member of the African-American clergy of Atlantic City be included on the Advisory Board described in N.J.A.C. 19:53-1.5.

RESPONSE: Although the Commission does not intend to specify the membership of the Advisory Board in the text of the actual rule, the Commission agrees that the commenter's request has merit and the Commission will act on it at the time the Advisory Board is created.

COMMENT: The DGE requested that a copy of all filings required by N.J.A.C. 19:53-2.4(a) be made with the DGE as well.

RESPONSE: The Commission agrees with the comment of the DGE and included this change as a minor substantive amendment at the time the rules were adopted. The DGE, by statute, is required to investigate and prosecute all potential violations of the Act and rules. N.J.S.A. 5:12-76. Although the DGE was inadvertently omitted as a recipient of the construction reports when the filing requirements were published, casino licensees and applicants should have known that the DGE was entitled to receive a copy of these filings.

COMMENT: The DGE suggested that a provision be added to the mandatory contract language contained in N.J.A.C.: 19:53-2.7, similar to that previously contained in N.J.A.C. 19:53-1.4(h)2, requiring contractors and subcontractors to provide information or reports upon request by the DGE or Commission.

RESPONSE: Contractors and subcontractors engaged in construction contracts on behalf of casino licensees or applicants are subject to qualification pursuant to N.J.S.A. 5:12-104(b). Accordingly, contractors and subcontractors are required by section 80 of the Casino Control Act to "provide any assistance or information required by the commission or division . . . " N.J.S.A. 5:12-80d. The Commission does not believe it is necessary to repeat this statutory requirement in the rules or in the mandatory contract language.

COMMENT: The Fellowship of Churches suggested that N.J.A.C. 19:53-2.4 be amended to provide for construction work force employment goals of 14 percent for women and 40 percent for minorities and that the minority employment goals for the operation work force be increased to 40 percent.

RESPONSE: The comments must be rejected by the Commission since the commenter failed to provide any factual or legal basis for the suggested revised goals.

COMMENT: N.J.A.C. 19:53-2.9 provides that any contractor or subcontractor which fails to meet the applicable construction employment goals for women or minorities during a calendar quarter shall have two additional calendar quarters in which to comply with the goals or document its good faith efforts to do so. The Fellowship of Churches suggested that N.J.A.C. 19:53-2.9 be amended to reduce the time period for achieving compliance from six months to three months.

RESPONSE: The Commission believes that six months is a reasonable period of time to permit a contractor or subcontractor which is out of compliance to attempt to reach the applicable employment goals or to create a sufficient documentary record of its efforts to do so; accordingly, the comment is rejected.

COMMENT: The ARC, the Public Advocate and EPVA each argued that the new rules should be modified to retain the previous affirmative action requirements applicable to casino service industry enterprises.

RESPONSE: One of the primary policy judgments made by the Commission when the new version of N.J.A.C. 19:53 was developed and approved for publication was that the Commission simply did not have sufficient resources to oversee the preparation and implementation of individualized affirmative action programs by each casino service industry enterprise. Accordingly, the rules contained in N.J.A.C. 19:53-3 set forth the fundamental equal employment and business opportunity obligations which each casino service industry enterprise licensee and applicant must observe in accordance with the requirements of the Act. In essence, these rules, which each casino service industry enterprise is obligated to acknowledge in writing (see N.J.A.C. 19:53-3.2(c)), constitute a generic affirmative action program applicable to all service industry enterprises. If an enterprise employs more than 50 employees in the State of New Jersey, the enterprise is also obligated to engage in basic affirmative action efforts, such as recruitment and referral, on behalf of women and minorities. In the opinion of the Commission, the obligations set forth in N.J.A.C. 19:53-3 not only comply with the equal employment opportunity requirements established by section 134 of the Act, but also strike a reasonable balance between the discretionary authority of the Commission to require affirmative action efforts by casino service industry enterprises and the ability of the Commission to oversee and enforce such efforts.

COMMENT: The Fellowship of Churches suggested that N.J.A.C. 19:53-3.3 be amended to require casino service industry enterprises to include all Atlantic City churches on their mailing lists when notices of available positions are circulated.

RESPONSE: Since casino service industry enterprises subject to this requirement may be located anywhere in the State of New Jersey, the Commission does not believe it would be appropriate to mandate in the rule that all such enterprises notify all churches in Atlantic City. The purpose of the rule is to require the enterprise to notify organizations which serve the interests of equal employment opportunity for women and minorities. Enterprises will be expected to make a reasonable effort to comply with this requirement. This does not mean that each enterprise will be required to contact all such organizations. Although Atlantic City churches may be appropriate organizations for enterprises in the Atlantic City area to consider for inclusion on their mailing lists, the Commission is not prepared to include this requirement in the rule at this time.

COMMENT: CANJ expressed the view that the employment goals for the operations work force established in N.J.A.C. 19:53-4.4 should not be uniform across all job categories, but should reflect the availability of workers to fill positions in specific EEOC job categories.

RESPONSE: As CANJ noted in its comments at the public hearing, the proposed new rules recognize, at N.J.A.C. 19:53-4.4(b), that employment goals for women and minorities in specific EEOC job categories may be promulgated by the Commission should comparable occupational data be available. Based in part on an analysis of occupational data obtained from 1990 U.S. Census figures submitted by the casino industry, the Commission has developed employment goals for each of the nine EEOC job categories. The women and minority employment goals for each job category have been included in a group of amendments to the new rules published in the Proposal section of this issue of the New Jersey Register.

COMMENT: The Hispanic Alliance commented that the Commission should require more data from casino licensees about persons who are interviewed for positions and those who are actually hired. This data would permit the Commission to better judge whether equal employment opportunity is actually being afforded by the casino industry.

RESPONSE: There are numerous ways to judge the adequacy of the equal employment opportunity efforts of casino licensees. As a matter of policy, the Commission has chosen in the new rules to minimize the amount of raw data which must be routinely submitted by a casino licensee in complying with the equal opportunity obligations of the Casino Control Act. The Commission maintains that the imposition of the equal opportunity requirements mandated by N.J.A.C. 19:53-4.1, in combination with the reports required by N.J.A.C. 19:53-4.5 and 4.6, are more than adequate in the context of an annual EEBOP review and assessment to evaluate the performance of the casino industry in this area. Should problems be discovered, the Commission has the authority to order appropriate remedial or curative actions by a casino licensee or to modify the rules to provide for additional monitoring of employment activities.

COMMENT: The DGE suggested that equal employment opportunity grievance procedures should be included in N.J.A.C. 19:53-3.3(a) and 4.3(a) in describing the affirmative action obligations of casino service industry enterprises and casino licensees, respectively.

RESPONSE: The Commission accepts the DGE's comment with regard to the affirmative action obligations of casino licensees under N.J.A.C. 19:53-4.3(a) and added the requested language as a minor substantive amendment at adoption. Casino licensees and applicants should have known that this language was inadvertently omitted from N.J.A.C. 19:53-4.3(a) since the responsibilities of the casino equal opportunity officer enumerated in N.J.A.C. 19:53-1.4(b)3 specifically referenced the need to address equal employment opportunity grievance procedures.

Conversely, the Commission rejects the DGE's comment with regard to N.J.A.C. 19:53-3.3(a), the obligations of casino service industry enterprises since the new rules reflect a conscious decision by the

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Commission to minimize the affirmative action obligations imposed on casino service industries. By comparison to the analysis above, the responsibilities of a casino service industry enterprise equal opportunity officer enumerated in N.J.A.C. 19:53-3.1 do not mandate the inclusion of equal employment opportunity grievance procedures.

COMMENT: The Community Health Law Project, the DDC, HAIL, the ARC, the Public Advocate, APSE, EPVA and the Morris County HRC commented that the new rules, by failing to provide employment goals for persons with disabilities in the same manner that such goals are provided for women and minorities, either violate the requirements of the Casino Control Act, are unconstitutional as a denial of equal protection under the New Jersey Constitution or constitute an abuse of discretion by the Commission. The commenters supported their arguments by citing employment figures obtained from the Commission, which were based on casino industry reports, indicating that only 165 persons with disabilities were employed in a casino industry work force of 42,000 persons. The Community Health Law Project also testified that 27 sections of the new rules refer to affirmative action efforts on behalf of minorities and women while only one section addresses the interests of persons with disabilities, and that section only refers to reasonable accommodation rather than affirmative action.

RESPONSE: The Commission disagrees with the legal analyses of the commenters. Section 134 of the Casino Control Act requires each applicant for a casino or casino service industry license to "formulate . . . and abide by an affirmative-action program of equal opportunity **whereby the applicant guarantees to provide equal employment opportunity** to rehabilitated offenders . . . and members of minority groups qualified for licensure in all employment categories, including the handicapped . . ." N.J.S.A. 5:12-134c (emphasis supplied). This language is consistent with that contained in subsection 134b which provides that "[n]o license shall be issued . . . to any applicant . . . **who has not agreed to afford an equal employment opportunity** to all prospective employees in accordance with an affirmative-action program approved by the commission and consonant with the provisions of the 'Law Against Discrimination' [citation omitted]." N.J.S.A. 5:12-134b (emphasis supplied).

The Commission does not know why the Legislature, in describing the statutory equal employment opportunity obligations to be imposed on applicants and licensees, chose to use the term "affirmative-action program." But the language highlighted above clearly indicates that the fundamental statutory obligation imposed on applicants and licensees relates solely to the provision of **equal employment opportunity.** Equal employment opportunity and affirmative action are totally separate legal concepts. The Casino Control Act and the Law Against Discrimination mandate that casino and casino service industry licensees and applicants provide equal employment opportunity to the disabled, ethnic minorities, and women, but not affirmative action.

This analysis, however, is not inconsistent with the conclusion that the Commission has the power to require affirmative action on the part of licensees and applicants when such measures are deemed necessary and appropriate. Section 135 of the Act gives the Commission the power to determine the percentage of population of minority groups in the areas from which the industry work force is drawn and to promulgate such percentages as guidelines in determining whether licensees and applicants are in fact affording equal employment opportunity as required by subsections 134b and c. The promulgation of such guidelines would not, in and of itself, constitute the imposition of an affirmative action obligation on licensees and applicants. Affirmative action obligations do not come into play until the Commission examines the employment figures and guidelines and, pursuant to its residual power to take whatever regulatory measures are deemed necessary and appropriate to carry out the policies of the Casino Control Act (see N.J.S.A. 5:12-69, 75 and 133), directs licensees and applicants to use those guidelines as goals in their employment practices.

Contrary to the legal opinion expressed by HAIL, the fact that the Commission has previously perceived a need to impose affirmative action employment goals for the benefit of ethnic minorities and women but not for persons with disabilities, is not an abuse of discretion by the Commission or a violation of the equal protection provisions of the New Jersey Constitution. Even if one assumes for purposes of argument that disabled persons are legally and factually entitled to affirmative action efforts by casino licensees, neither administrative fairness nor equal protection requires that an administrative agency address all the issues confronting it in the same manner or at the same time. Nevertheless, the current factual record does not support the conclusions urged by the commenters.

Other than the employment figures cited above, not one of the commenters has suggested that they are aware of any evidence which would indicate that persons with disabilities are treated in a discriminatory manner by casino licensees or that the casino industry has not in fact been a cooperative partner in the effort to bring disabled persons into the mainstream of the employment work force. Moreover, the Commission is not aware of any information from any other source which would indicate that there is any basis whatsoever to assume that disabled persons have not received complete equal employment opportunity from the casino industry.

Conversely, the only factual information which the Commission has received from persons involved in the local disabled community indicates that the casino industry has an outstanding record in assisting disabled persons to obtain employment in the industry. This information goes back as far as 1987 when the Commission, at the behest of the Community Health Law Project and others who suggested that employment goals for the disabled were appropriate at that time, published a preproposal to solicit the views of interested persons on the subject (see 19 N.J.R. 1182(a)).

In this preproposal, the Commission requested interested persons with expertise in the area to address various difficult issues which the Commission believed needed to be resolved before employment goals for the handicapped could even be considered. Although the Community Health Law Project chose not to respond to this request for assistance, various authoritative figures with experience in the area, including the State Division on Civil Rights, persuasively argued that employment goals were not an effective means of meeting the employment needs of disabled persons. Those commenters who were actually familiar with the performance of the casino industry in responding to the needs of disabled persons, praised the efforts of most casino licensees. Although the Commission subsequently requested the Community Health Law Project to provide the Commission with any information in its possession which indicated that qualified disabled persons had in fact had difficulty in applying for or obtaining employment with casino licensees, again, no answer was forthcoming. Based on the comments submitted by Mr. David Delaney which are summarized below, the industry's outstanding record with regard to the employment of the disabled apparently continues today.

As to the employment figures cited by the commenters, the Commission clearly indicated that these numbers were unreliable and incomplete at the time they were provided to the Community Health Law Project. The Commission acknowledges that it does not have accurate information on the number of disabled persons currently employed by the casino industry, but neither do the commenters. This lack of reliable information is based in large part on the practical difficulty of getting disabled persons to identify themselves on a voluntary basis, since mandatory disclosure is prohibited by law. As will be discussed below, the Commission is now hopeful that this reporting problem can be successfully addressed. Once this is accomplished, the Commission will be in a position to better judge whether any affirmative regulatory requirements concerning disabled persons are necessary or appropriate.

Finally, the fact that 27 sections of the new rules deal with affirmative action efforts on behalf of ethnic minorities and women and only one section addresses programs for persons with disabilities is a logical consequence of the fact that the rules do not impose employment or business goals for persons with disabilities. This tautology proves nothing. The present determination of the Commission not to impose employment goals for persons with disabilities is more than amply supported by the legal and factual bases stated above.

Notwithstanding the absence of any evidence that the casino industry has failed to afford equal employment opportunity to disabled persons and in spite of the evidence to the contrary, the Commission remains committed to assuring that equal employment opportunities for qualified disabled persons are afforded by all casino licensees. Unfortunately, with the exception of the positive information which has been presented by the Bureau of Economic Research in this proceeding, the Commission is no closer today to resolving the legal and factual issues which were raised in its rule preproposal than it was in 1987. Accordingly, before taking any action other with regard to affirmative action efforts for the disabled, the Commission is proposing an amendment to new rule N.J.A.C. 19:53-1.5 which would establish a separate Advisory Board on the Disabled. This Advisory Board will consist of representatives of the casino industry, advocacy groups for the disabled and members of the regional disabled community. The immediate responsibility of this Advisory Board will be to investigate and develop regulatory initiatives

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regarding the disabled, such as the implementation of an accurate and reliable reporting system. This proposed amendment is published in the Proposal section of this issue of the New Jersey Register.

COMMENT: Mr. David Delaney, who cited his present and historical involvement in a number of organizations which serve the interests of disabled persons in the Atlantic County region, noted that, to his knowledge, no member of the Community Health Law Project had ever contacted any member of any local organization to discuss the record of the casino industry in assisting persons with disabilities. According to Mr. Delaney, the casino industry has an admirable record of supporting the disabled, a record which has been acknowledged on several occasions over the past several years through the issuance of awards to casino licensees by the district office of the Social Security Administration. The industry has been actively involved in local advocacy organizations for the disabled and has placed many disabled employees with casino licensees through participation in job fairs for the disabled. According to Mr. Delaney, not only has "almost every [casino licensee] hired . . . individuals who are disabled," the "casino properties have been willing to listen, participate, and learn about the issues affecting those individuals with disabilities including how they can be assets at the workplace."

Interestingly, Mr. Delaney strongly opposed the imposition of numerical goals for the employment of the disabled. According to Mr. Delaney, disabled persons do not need to be recognized for their disabilities, but rather for their abilities. Mr. Delaney expressed the view that goals for disabled persons would be extremely difficult to administer and would only serve to further isolate the disabled from the remainder of the work force. Rather, he would like to encourage the casino industry to continue their active involvement in the local disabled community.

RESPONSE: The Commission, based on the facts presented to date, agrees with the comments submitted by Mr. Delaney.

COMMENT: The Community Health Law Project, HAIL, the ARC and APSE each opposed the elimination of disabled persons from the work force composition reports which were previously filed by casino licensees. The Bureau of Economic Research expressed the opinion that there were no technical or informational reasons why persons with disabilities who are employed by casino licensees could not be accurately identified and compared to the percentage of disabled persons in the general work force.

RESPONSE: The Commission eliminated the reporting of disabled employees in the new rules because the figures which resulted from such reports indicated that the reports were meaningless. Anyone who looked at the results, including the disabled advocates who tried to rely on the figures cited above at the public hearing on the rules, had to know that this information was inaccurate. Two of the commenters admitted this during the course of the hearing. Since the Commission's previous requests for assistance in determining an accurate means of identifying and reporting disabled employees had gone unheeded, the Commission determined to delete the information concerning disabled employees from the work force composition report.

For the first time, however, someone with expertise in the field, the Bureau of Economic Research, has indicated that it could assist the Commission in developing a reliable means of determining the number of disabled persons actually employed in the casino industry. It is clear that no one really knows how many disabled persons are currently employed in the casino industry or how that number would compare to the general work force. Thus, as noted above, one of the designated responsibilities of the Advisory Board on the Disabled which would be created by the amendments to N.J.A.C. 19:53 proposed in this issue of the New Jersey Register, would be to develop an accurate means of identifying the number of disabled persons presently employed in the casino industry. It is anticipated that this Advisory Board will take advantage of the expertise of the Bureau of Economic Research in meeting this responsibility.

COMMENT: The Community Health Law Project, HAIL and EPVA expressed the opinion that the new rules provide less affirmative action for disabled persons than did the previous rules.

RESPONSE: Although neither the Community Health Law Project nor HAIL explained how the new rules are worse than the previous rules in terms of their treatment of the disabled, EPVA based its comment on the belief that the new rules eliminated an affirmative obligation to recruit disabled persons which was previously contained in N.J.A.C. 19:53-1.5(a)2. Although EPVA is correct in that N.J.A.C. 19:53-1.5(a)2 previously required licensees and applicants to recruit and employ disabled persons at all levels of the work force, a careful reading of N.J.A.C. 19:53-1.5(a)2 reveals that this section required licensees and applicants to recruit and employ all persons protected by the Law Against Discrimination, which includes virtually every person in the work force. Thus, the benefit which was supposedly lost was of minimal, if any, value when compared to the rights of any other potential employee.

Conversely, the new rules require each casino licensee and applicant to include in its EEBOP "provisions which address the efforts of the casino licensee or applicant to employ and advance persons with disabilities." N.J.A.C. 19:53-4.2. Although this new rule, consistent with the regulatory theory which requires each casino licensee to initially define the elements of its EEBOP, does not specifically impose out-reach programs, participation in job fairs and similar obligations with regard to the disabled, it is fully anticipated that each casino licensee will include such programs or other creative measures in their EEBOPs when identifying how they will seek to advance the interests of the disabled. Unlike the previous requirements of N.J.A.C. 19:53-1.5(a)2, the requirements of N.J.A.C. 19:53-4.2 only apply to disabled persons.

COMMENT: The Newark MBDC, Mr. Joe Brown and the NAACP commented that the rules should establish separate goals for MBE and WBE utilization.

RESPONSE: Until there is a significant pool of certified or provisionally certified MBEs and WBEs from which casino licensees can purchase goods and services, the Commission is reluctant to establish separate goals for each group. The Commission is cognizant, however, of the concern of minority businesses that casino licensees will satisfy their participation goals by making the bulk of their expenditures with women-owned businesses. The new rules provide, at N.J.A.C. 19:53-5.3(d), that every casino licensee shall make a good faith effort to distribute the dollar value of its contracts for goods and services equitably between MBEs and WBEs. The Commission will thus monitor the distribution of such business in the future and, if necessary, take remedial action or propose additional regulatory changes.

COMMENT: The Newark MBDC, the Black Issues Convention and the NAACP all expressed support for the concept of provisional certification of MBEs and WBEs, but also expressed concern that the concept would not prove beneficial unless the Commission strictly enforces the rules and imposes severe sanctions on persons who fraudulently represent their status.

RESPONSE: The Commission generally agrees with these comments although the Commission believes it would be inappropriate to assume that all cases of false certification should be dealt with in the same manner. Each such case must be judged on its own facts and circumstances. The Commission does intend, however, to strictly enforce the provisions of N.J.A.C. 19:53-5.4(i), which permits the Commission to prohibit any enterprise which makes a material representation as to its MBE/WBE status from doing business with any casino licensee or applicant for a period of five years.

COMMENT: The Newark MBDC indicated its support for the quarterly monitoring of casino licensee disbursements since monitoring will help to assure compliance. Conversely, the commenter was concerned that significant problems will only be dealt with at the annual review of the licensee's compliance with its EEBOP.

RESPONSE: The Commission agrees with the commenter's assessment of the value of quarterly reporting as required by N.J.A.C. 19:53-5.7. The Commission would note, however, that the commenter's concern that significant problems will only be addressed on an annual basis is misplaced. N.J.A.C. 19:53-6.9, "Special EEBOP reviews and hearings," permits the Commission to require a casino licensee to conduct a self-assessment of any portion of an EEBOP at any time and to direct that a hearing be held concerning same to determine whether the casino licensee should be required to make immediate modifications to its EEBOP.

COMMENT: The General Baptist Convention expressed the opinion that the Commission will need to take an active role in requiring casinos to reach out to minority and women companies because casinos will not make the effort on their own. The Commission should create some kind of central clearinghouse so that minority and women vendors who wish to do business with casinos can be readily identified by the casinos.

RESPONSE: The Commission has, for the past year, maintained a directory of certified and provisionally certified MBEs and WBEs who are interested in doing business with casino licensees and applicants. The codification of this directory in the rules at N.J.A.C. 19:53-5.4(f) should make more women and minority enterprises aware of the existence of

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the directory and encourage more enterprises to apply for certification so that casino licensees can obtain credit for goods and services purchased from them.

COMMENT: The Mercer County OSMB questioned why the rules do not give casino licensees credit for business done with MBEs and WBEs located outside of Atlantic City. It was also suggested that the Commission or casino licensees should make a greater effort to publicize casino business opportunities throughout the State.

RESPONSE: There is no restriction in the rules as to the geographical location of certified or provisionally certified MBEs or WBEs with whom casino licensees can do business for credit. As to publicizing casino business activities, it should be noted that the Commission has no direct involvement in the specific contractual activities of casino licensees. It is anticipated, however, that each casino licensee's EEBOP will specify the manner in which notices of contracting opportunities will be publicized, particularly as to minority and women business enterprises. If the Mercer County OSMB has any suggestions as to how individual casino licensees might provide notice of contractual opportunities to vendors around the State, the commenter is encouraged to advise the individual licensees or CANJ of its suggestions.

COMMENT: The Allen A.M.E. Church expressed the view that the goal for casino business with minority business enterprises should be higher, perhaps as high as 50 percent, in order to eradicate the inequality which currently exists.

RESPONSE: The minority and women business enterprise participation goals set forth in N.J.A.C. 19:53-5.3 are based on the voluntary 1981 agreement whereby casino licensees undertook to guarantee that 15 percent of their spending for goods and services would enure to the benefit of MBEs, the historical performance of casino licensees in this area, comparable goals established by the State of its own purchasing programs and the Commission's knowledge of the overall purchasing activities of casino licensees. The Commission does not believe it would be appropriate to modify these goals at this time without a definitive factual basis justifying such a modification.

COMMENT: The NAACP suggested that, in determining the expenditures of casino licensees that are subject to the participation goals for MBEs and WBEs (see N.J.A.C. 19:53-5.5), there should be no exemption where there exists any opportunity for entrepreneurship.

RESPONSE: The Commission agrees with the comment of the NAACP and attempted to draft N.J.A.C. 19:53-5.5 in accordance with this standard. If the NAACP has any specific suggestions as to how the field of exemptions could be further narrowed, the Commission would certainly consider these suggestions in future regulatory amendments.

COMMENT: The NAACP expressed the view that the Commission should not give any dollar credit for good faith efforts; casino licensees should only get credit for dollars spent with qualifying vendors.

RESPONSE: Although the Commission appreciates the position of the NAACP, the Commission believes that situations will arise where it would be unfair to find that a casino licensee failed to meet its participation goals simply because the required number of dollars were not actually spent. For example, a casino licensee may have contemplated meeting its goals through contracts with one or more MBEs or WBEs who, through no fault of the casino licensee, went out of business before the contemplated goods or services were delivered. Similarly, until there is a larger pool of certified and provisionally certified MBEs and WBEs, it is possible to envision situations where a casino licensee, despite its best efforts, may not be able to enter a sufficient number of contracts for needed goods and services to meets its participation goals. The Commission does not believe it would be appropriate in either of these scenarios to find the casino licensee in violation for its failure to reach its participation goals.

Moreoever, a fundamental premise of the regulatory scheme pursuant to which an individualized EEBOP is to be prepared by each casino licensee is that some casino licensees may wish, during some annual review periods, to engage voluntarily in mentoring or other business development programs for WBEs, MBEs and Atlantic City small businesses in lieu of or in addition to making dollar expenditures. Thus, a casino licensee's compliance with its affirmative action obligations with regard to MBEs and WBEs must, of necessity, be judged by the compliance of the licensee with the terms of its EEBOP rather than by looking at dollar expenditures alone.

COMMENT: Middleton Development Corporation suggested that the rules be modified to encourage the use of minority and women enterprises in the operation of projects or facilities after they are constructed.

RESPONSE: The Commission believes the commenter is misreading the rules if it believes that the rules favor construction vendors over any other type of vendor. Casino licensees may receive credit for goods or services purchased from any certified or provisionally certified MBE or WBE. The credit which is available for contracts which call for the operation or maintenance of a facility by a qualified MBE or WBE is just as valuable to a casino licensee as the credit to be obtained through the use of an MBE or WBE construction firm.

COMMENT: The Community Health Law Project, the DDC and the Morris County HRC each commented that the new rules violate the Casino Control Act because they promote business opportunities for enterprises owned by women and minorities but do not make any similar provisions for businesses owned by disabled persons. DDC suggested that a five percent participation goal should be established for casino purchases of goods and services from disabled business enterprises.

COMMENT: Unlike the equal employment opportunity obligations imposed on casino licensees by section 134 of the Act, which are statutorily applicable to all minorities, including the handicapped, no provision of the Casino Control Act suggests that casino licensees should be required to engage in affirmative action efforts to provide enterprises owned by disabled persons with casino business opportunities. The Commission would again maintain that it possesses the inherent discretionary authority to impose such obligations should the Commission find that such actions are necessary or appropriate to carry out the policies of the Casino Control Act. There is no record before the Commission at this time, however, which would support the discretionary imposition of such affirmative action requirements on casino licensees.

COMMENT: The Newark MBDC suggested that a mentor/protege program similar to that currently utilized by the U.S. Department of Defense should be included in the rules defining the business section of an EEBOP. Promatech, Inc. suggested that the rules should include a mentoring program modeled after the program used by the New York City School Construction Authority.

RESPONSE: The rules defining the discretionary elements of the business section of an EEBOP, N.J.A.C. 19:53-6.5(b), already suggest that a casino licensee may wish to include "mentoring and other appropriate business development activities" in this section of its plan. Although the Commission appreciates the commenters making it and the casino industry aware of mentoring programs which may serve as models for activities to be undertaken by casino licensees, the Commission does not believe it would be appropriate to include references to specific programs in the rule.

COMMENT: The Black Issues Convention expressed its concern that the good faith efforts of casino licensees be recognized when such efforts are actually made and sanctioned when such efforts are lacking.

RESPONSE: The Commission agrees with the comment of the Black Issues Convention. The successful implementation of the regulatory scheme will depend in large part on compliance by each casino licensee with the terms of its approved EEBOP. Any failure by a casino licensee to implement its EEBOP, unless otherwise addressed in accordance with the terms of N.J.A.C. 19:53-6, should result in significant sanctions being imposed against the casino licensee.

COMMENT: The Tallahassee Neighborhood Trust suggested that the benefits of the rules should be made available to all small businesses, not just those owned and operated by minorities or women. Franklin Electric Company expressed its support for the policy which encourages casino licensees to do business with Atlantic City small enterprises.

RESPONSE: As indicated by the comment of Franklin Electric Company, the new rules do encourage casino licensees, in N.J.A.C. 19:53-6.6, to include strategies and objectives in their EEBOPs which are intended to foster the development of Atlantic City small businesses.

**Summary** of Agency-Initiated Changes:

In order to clarify that the employment and advancement of persons with disabilities is a primary duty of a casino licensee or applicant, the list of responsibilities of the chief executive officer contained in N.J.A.C. 19:53-1.4 was amended to specifically include the promulgation and enforcement of the policy otherwise specified in N.J.A.C. 19:53-4.2. A technical change was made to N.J.A.C. 19:53-2.5(c) to correct a typographical error. Another technical change was made to N.J.A.C. 19:53-2.8 to correct a codification error.

The minor substantive amendments to N.J.A.C. 19:53-2.9 and 2.10 were made to eliminate any potential confusion as to the basis on which the performance of a contractor or subcontractor is meeting the employment goals of N.J.A.C. 19:53-2.3 will be judged. Whereas such performance was previously measured based on the number of workers

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employed in each class, the new rule N.J.A.C. 19:53-2.8 makes clear that performance in the future is to be measured based on the number of hours worked by employees in each class. This change was instituted in order to avoid the situation where minority or female workers were employed on a part-time basis but compared to workers who were employed for substantially more hours. The minor substantive amendments to N.J.A.C. 19:53-2.9 and 2.10 make clear that the quarterly and annual evaluations of contractors and subcontractors will be based on the percentages derived from the total number of hours worked by employees in each class.

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

CHAPTER 53
EQUAL EMPLOYMENT AND BUSINESS OPPORTUNITY

SUBCHAPTER 1. GENERAL PROVISIONS

19:53-1.1 Scope, policy and purpose

(a) It has long been the public policy of the State of New Jersey to promote equal employment and business opportunity by prohibiting discrimination and by encouraging businesses to achieve a balanced representation of employees at all levels of the work force and to contract with and purchase goods and services from all persons. Consistent with this public policy, the Act and the rules of the Commission empower the Commission to monitor and evaluate the good faith efforts of all licensees and applicants to achieve these goals.

(b) These rules are adopted in order to establish equal employment opportunity and equal business opportunity requirements for casino licensees and applicants, casino service industry enterprise licensees and applicants and construction contractors and subcontractors engaged in construction projects for casino licensees and applicants. These rules also establish affirmative action requirements for casino licensees and applicants, certain casino service industry enterprise licensees and applicants and construction contractors and subcontractors with regard to the employment of women and minorities. Finally, these rules establish affirmative action requirements for casino licensees with regard to the purchase of goods and services from certified and provisionally certified minority and women business enterprises.

19:53-1.2 Definitions

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

"Adjusted gross disbursements" means gross disbursements minus allowable administrative costs and allowable direct labor costs as defined in N.J.A.C. 19:53-5.5.

"Affectional or sexual orientation" is defined in N.J.S.A. 10:5-5.

"Apprentice" means a worker who is classified by a union or other party acceptable to the Commission as having experience and skills used in a particular construction craft or occupation, but lacking the skills to be qualified as a journeyworker.

"Atypical hereditary cellular or blood trait" is defined in N.J.S.A. 10:5-5.

"Bus" means any "autobus" as defined in N.J.S.A. 48:4-1; provided, however, that for purposes of this chapter such term shall include any autobus engaged in intrastate or interstate commerce.

"Certified MBE" or "certified WBE" means any business enterprise which has been certified by the Department of Commerce and Economic Development pursuant to N.J.A.C. 12A:11 as a minority business enterprise or a women business enterprise, respectively.

"Change in ownership or management" means any change in the ownership or management of a licensee or applicant which could enable an involuntary change in the existing policy of the licensee or applicant to occur, and shall include, without limitation, the sale of a controlling interest in the licensee or applicant or a holding company thereof, or the replacement of the chief executive officer of the licensee or applicant.

"Chief executive officer" means:

1. As to casino licensees or applicants, the natural person located at a casino hotel facility who is ultimately responsible for the daily conduct of the hotel and gaming business of the casino licensee or applicant, regardless of the form of business association of the casino licensee or applicant or the particular title which the person holds.

2. As to casino service industry enterprise licensees or applicants, the natural person who bears ultimate responsibility for the organization and business activities of the enterprise.

"Construction" or "renovation" or "reconstruction" means any construction, renovation, reconstruction, rehabilitation, alteration, conversion, extension, demolition, repair or other changes or improvements of any kind whatsoever of any structure or facility to be used as an approved hotel, casino, casino simulcasting facility or related facility. These terms also include the maintenance, supervision, inspection, and other on-site functions incidental to the actual construction.

"Contract" means any written or unwritten agreement between two or more persons.

"Contractor" means any party performing or offering to perform pursuant to a contract.

"DCED" means the New Jersey Department of Commerce and Economic Development.

"Disability" means a physical or mental impairment which is included in the definition of "handicapped" contained in the Law Against Discrimination, N.J.S.A. 10:5-5, or in the definition of "disability" contained in the Americans with Disabilities Act of 1990, 92 USC 12101, and attendant regulations.

"EEOC job categories" is defined in N.J.A.C. 19:53-1.3.

"Equal business opportunity" means the opportunity of any person to buy from, sell to, lease from or to, license, contract with, trade with, provide goods, services or information to, or do business with any other person without regard to the race, creed, color, national origin, ancestry, affectional or sexual orientation, gender, age, marital status, nationality, atypical hereditary cellular or blood trait, liability for service in the armed forces of the United States, disability (where reasonable accommodation may be made to allow for such disability without causing an undue hardship on the person doing business) or rehabilitated offender status of such person or such person's partners, members, stockholders, directors, officers, managers or employees.

"Equal Employment and Business Opportunity Plan (EEBOP)" is defined in N.J.A.C. 19:53-6.

"Equal employment opportunity" means the opportunity of any person to apply for, obtain and retain employment, transfer, promotion, pay raises, benefits and training without regard to the race, creed, color, national origin, ancestry, affectional or sexual orientation, gender, age, marital status, nationality, atypical hereditary cellular or blood trait, liability for service in the armed forces of the United States, disability (where reasonable accommodation may be made to allow for such disability without causing an undue hardship on the employer) or rehabilitated offender status of such person.

"Equal opportunity officer" means a person appointed by a licensee or applicant, pursuant to the provisions of N.J.S.A. 5:12-135f and N.J.A.C. 19:53-1.4 or 3.1, to assure its compliance with this chapter and any Federal or State laws regarding equal employment and business opportunity.

"Gross disbursements" means the total amount of money spent for any purpose whatsoever by a casino licensee.

"Journeyworker" means a worker who has been certified by a union or other party acceptable to the Commission as having mastered a craft or trade.

"Liability" for service in the armed forces of the United States is defined in N.J.S.A. 10:5-5.

"MBE" means a minority business enterprise.

"Minority" means a person who is:

1. African American, who is a person having origins in any of the black racial groups in Africa;

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2. Hispanic, who is a person of Spanish or Portuguese culture, with origins in Mexico, South or Central America, or the Caribbean Island, regardless of race; or

3. Asian American, who is a person having origins in any of the original peoples of the Far East, Southeast Asia, Indian Subcontinent, Hawaii, or the Pacific Islands.

"Minority business" is defined in N.J.A.C. 19:53-5.4.

"Net disbursement" is defined in N.J.A.C. 19:53-5.5.

"Operations work force" means all employees of a casino licensee or applicant who work in or in support of the casino hotel, casino, casino simulcasting facility or a related facility.

"Project" means the objective of a construction contract or subcontract. The same project may involve more than one contract or subcontract.

"Project Labor Report" is defined in N.J.A.C. 19:53-2.8.

"Project Labor Report Summary" is defined in N.J.A.C. 19:53-2.4.

"Project Status Report" is defined in N.J.A.C. 19:53-2.4.

"Provisionally certified MBE" or "provisionally certified WBE" means an enterprise which has attested to its status as an MBE or WBE, respectively, pursuant to the provisions of N.J.A.C. 19:53-5.4.

"Rehabilitated offender" means any person who has been convicted of or has committed a disqualifying offense pursant to N.J.S.A. 5:12-86 and who has been found rehabilitated from such offense pursuant to the provisions of N.J.S.A. 5:12-90h or 91d.

"Subcontract" means a binding legal relationship involving performance by a subcontractor of all or part of a contract or subcontract.

"Subcontractor" means any party engaged by a contractor or subcontractor to perform, under a subcontract, all or part of the work included in a contract or subcontract.

"WBE" means women business enterprise.

"Women business enterprise" is defined in N.J.A.C. 19:53-5.4.

19:53-1.3 Classification of employees; use of EEOC job categories

(a) Whenever the rules in this chapter require a licensee or applicant to classify employees or job titles by job category, the licensee or applicant shall use the nine broad occupational classifications developed by the U.S. Equal Employment Opportunity Commission (EEOC), as adapted or modified by the rules of the Commission in (b) below. When required, the licensee or applicant shall also provide data concerning the four subclasses of Officials and Managers as described in (b) below.

(b) The EEOC job category classifications and subclassifications to be used by licensees and applicants are, in order, as follows:

1. "Officials and Managers" are occupations in which employees set broad policies, exercise overall responsibility for implementation of these policies, direct individual departments or special phases of the organization's operations, provide specialized consultations on a regional, district or area basis, or supervise or assist in the supervision of specific work units. This category shall include, without limitation, occupations such as chief executive officer, president, vice president, director, assistant director, equal opportunity officer, manager, assistant manager, pit boss, shift supervisor, floorperson and boxperson. Unless otherwise specified in an approved EEBOP, this category shall consist of four subclassifications defined by compensation range as follows:

i. "Subclass I" are positions whose actual salaries are $95,000 and above.

ii. "Subclass II" are positions whose actual salaries are from $75,000 to $94,999.

iii. "Subclass III" are positions whose actual salaries are from $55,000 to $74,999.

iv. "Subclass IV" are positions whose actual salaries are from $35,000 to $54,999.

2. "Professionals" are occupations which require specialized knowledge which is usually acquired through college training, work experience or other training which provides comparable knowledge. Examples include human resources or labor relations personnel and dealers.

3. "Technicians" are occupations which require a combination of basic scientific or technical knowledge and manual skills which can be obtained through specialized post-secondary school education or through equivalent on-the-job training. Examples include computer programmers and operators, stage and sound technicians and slot mechanics.

4. "Salesworkers" are occupations engaging wholly or primarily in selling goods or services, such as sales clerks and cashiers.

5. "Office and Clerical" are occupations in which workers are responsible for internal and external communications and the recording and retrieval of data or information and other paperwork required in an office. Examples include secretaries, bookkeepers and telephone operators.

6. "Craftpersons" are occupations in which workers perform jobs generic to the building and construction trades and which are covered by collective bargaining agreements. Such jobs require special manual skills and a detailed and comprehensive knowledge of the processes involved in the work, which is acquired through on-the-job training and experience or through apprenticeship or other formal training programs. Examples include journeyworkers in the building trades.

7. "Operatives" are occupations in which there is an intermediate skill level which can be mastered in a few weeks and requires only limited training, such as auto services and parking attendants, seamstress, butchers and carvers, chauffeurs, laundry and drycleaning workers and boiler room operators.

8. "Laborers" are occupations which require the performance of elementary duties which may be learned in a few days and require the application of little or no independent judgment, such as car washers, groundskeepers, and laborers performing lifting, digging, mixing, and loading.

9. "Serviceworkers" are occupations in which workers perform duties which result in or contribute to the comfort and convenience of the general public such as cleaners, cooks, porters, and food and cocktail servers.

19:53-1.4 Designation of equal opportunity officer by casino licensee or applicant; responsibility of chief executive officer and equal opportunity officer

(a) Each casino licensee or applicant shall designate a principal member of its organization to serve as an equal opportunity officer. A casino license applicant shall designate its equal opportunity officer prior to the start of actual construction by the applicant or by any affiliated entity of any structure or facility to be used as an approved casino hotel, or prior to the recruitment and employment of personnel necessary to undertake the business of the hotel or casino, whichever first occurs. The chief executive officer shall be ultimately responsible for insuring that equal employment opportunity is afforded to all prospective and actual employees, that equal business opportunity is afforded to all persons, that affirmative efforts are made to recruit and employ women and minorities for positions in which the licensee or applicant is below the applicable employment goals, that the casino licensee makes affirmative efforts to achieve the applicable participation goals for business with certified and provisionally certified MBEs and WBEs, ***that a policy advocating the employment and advancement of persons with disabilities is promulgated and enforced,*** and that the licensee or applicant achieves full implementation of its approved EEBOP. The equal opportunity officer shall be directly responsible for the organization and effective and continuing implementation of its approved EEBOP. The position of equal opportunity officer shall require a casino key employee license endorsed as such.

(b) The responsibilities of the equal opportunity officer shall include, without limitation, the responsibility to:

1. Monitor and review all aspects of the personnel procedures and decisions of the casino licensee or applicant;

2. Recommend in writing to the chief executive officer the suspension of any personnel procedure, decision or transaction which is not consonant with the approved EEBOP of the casino license or applicant or with any Federal or state law regarding equal employment opportunity or affirmative action; and

3. Act as a liaison and to provide assistance to the Commission and the Division in the enforcement of section 134 of the Act and this chapter, which responsibility shall include, without limitation,

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the obligation to prepare and submit such reports, documentation and statistical information as the Commission shall require concerning the licensee's or applicant's:

i. Work force composition;

ii. Efforts to assure that equal employment opportunity is being afforded to persons with disabilities and rehabilitated offenders;

iii. Good faith efforts to meet any applicable employment goals;

iv. Employment, promotion, demotion or transfer decisions;

v. Recruitment, recruitment advertising and union referral efforts;

vi Rates of pay or other forms of compensation;

vii. Training programs and selection procedures;

viii. Layoff, recall or termination decisions; and

ix. Grievance procedures for, and disposition of, complaints related to equal employment opportunity.

(c) In addition to the responsibilities specified in (b) above, the equal opportunity officer shall have the responsibility to:

1. Monitor and review all aspects of the contracting and purchasing procedures and decisions of the licensee or applicant;

2. Recommend in writing to the chief executive officer the suspension of any contracting or purchasing procedure, decision, or transaction which is not consonant with its approved EEBOP or with any Federal or State law regarding equal business opportunity;

3. Act as a liaison and to provide assistance to the Commission and the Division in the enforcement of the Act and this chapter, which responsibility shall include, without limitation, the obligation to prepare and submit such reports, documentation and statistical information as the Commission shall require concerning the activities of the licensee or applicant with certified and provisionally certified MBEs and WBEs in contracting and purchasing; and

4. Act as a liaison and provide assistance to the Department of Commerce and Economic Development with respect to its responsibilities to certify MBEs and WBEs.

(d) In addition to the responsibilities specified in (b) and (c) above, the equal opportunity officer shall have the responsibility to:

1. Monitor and review the employment, recruitment and union referral practices of all contractors and subcontractors used in connection with the actual construction, renovation or reconstruction of any structure or facility to be used as an approved hotel, casino, casino simulcasting facility or any related facility;

2. Recommend in writing to the chief executive officer the suspension of any contract or subcontract or payment thereof where the contractor or subcontractor is engaging in any employment, recruitment, referral or bidding practice which is not consonant with the Act or the rules of the Commission or with any Federal or State law regarding equal employment and business opportunity or affirmative action;

3. Accompany the Commission and the Division, if requested, during on-site inspections authorized pursuant to N.J.A.C. 19:53-2.7; and

4. Prepare and submit to the Commission and Division such reports, documentation and statistical information as the Commission shall require concerning any contractor or subcontractor used by the licensee or applicant in connection with the construction, renovation or reconstruction of any structure or facility to be used as an approved hotel, casino, casino simulcasting facility or any related facility including, without limitation, information concerning:

i. Work force composition;

ii. Good faith efforts to meet any applicable employment goals;

iii. Employment, promotion, demotion or transfer of skilled construction worker;

iv. Recruitment, recruitment advertising and union referral efforts;

v. Layoff, recall or termination of construction workers;

vi. Rates of pay or other forms of compensation;

vii. Selection for training programs; and

viii. Grievance procedures for, and disposition of, complaints related to equal employment opportunity.

(e) In addition to any other requirements imposed by this section, a casino licensee or applicant shall comply with the following requirements concerning its equal opportunity officer:

1. The equal opportunity officer designated by the casino licensee or applicant shall have a minimum of three years experience in equal employment and business opportunity plan implementation or affirmative action enforcement, which experience may not be waived, and either:

i. Two years of related experience drawn from any of the following areas: employment, recruitment, training, labor relations, employee relations, employee development, compensation and benefits administration, law, or statistics; or

ii. A bachelor's degree from an accredited institution.

2. The principal areas of responsibility of the equal opportunity officer shall be the implementation, monitoring and enforcement of the equal employment and business opportunity and affirmative action requirements established by the Act and this chapter. These responsibilities may include, without limitation, the following functions: recruitment; equal employment opportunity awareness training; legal and statistical analysis of work force composition and utilization; grievance counselling and fact-finding; career advancement counselling; assessment and adaptation of all personnel and compensation policies and procedures for conformity with the equal employment and business opportunity plan approved by the Commission and with any Federal or State equal employment and business opportunity laws; monitoring and coordinating contracting, purchasing and construction activities; and developing and maintaining the involvement of the licensee or applicant in the community in support of equal employment and business opportunity and affirmative action goals.

3. The title, rank and level of compensation of the equal opportunity officer shall be comparable to that of a director of a major department within the organization of the casino licensee or applicant.

4. The equal opportunity officer shall be provided with a staff sufficient to achieve full and timely implementation and enforcement of the EEBOP approved by the Commission and compliance with the Act and this chapter.

5. The equal opportunity officer shall report directly to the chief executive officer of the licensee or applicant or, in his or her absence, to the chief legal officer of the licensee or applicant.

(f) Whenever the equal opportunity officer of a casino licensee or applicant makes a suspension recommendation to the chief executive officer pursuant to (b)2, (c)2, or (d)2 above, a copy of the recommendation shall be maintained on file by the casino licensee or applicant for inspection by the Commission or Division upon request.

19:53-1.5 Advisory board

The Commission may establish an advisory board consisting of local or State officials, representatives of area businesses and communities, women and minority organizations, union officials, disabled persons, casino industry representatives or other interested parties. Such advisory board may make recommendations to the Commission, upon its request, concerning policies or techniques to assure equal employment opportunity for all persons and the participation of certified and provisionally certified MBEs and WBEs in purchasing and contracting in the casino industry and the casino-related construction industry.

19:53-1.6 Powers of the Commission; effect of rules

(a) Nothing in this chapter shall be construed as limiting the powers of the Commission or the Division as granted by the Act.

(b) Nothing contained in this chapter shall be interpreted to supplant, diminish, limit or in any way affect the scope and application of the Law Against Discrimination, N.J.S.A. 10:5-1 et seq., Title VII of the Civil Rights Act of 1964, 42 U.S.C.A. sec. 2000(e), or any other law regarding equal employment opportunity, equal business opportunity or affirmative action.

19:53-1.7 Enforcement and compliance; role of the Division

Pursuant to section 76 of the Act, the Division shall assist the Commission in the enforcement of any applicable provisions of the Act and this chapter by prosecuting before the Commission proceedings for violation of the Act and this chapter and by providing the

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Commission with information necessary for proceedings involving enforcement of any of the applicable provisions of the Act and this chapter.

19:53-1.8 Severability

If any clause, sentence, subparagraph, paragraph, subsection, section, subchapter or other portion of these rules or the application thereof to any person or circumstance shall be held to be invalid, such holding shall not affect, impair or invalidate the remainder of these rules or the application of such portion held invalid to any other person or circumstances, but shall be confined in its operation to the clause, sentence, subparagraph, paragraph, subsection, section, subchapter, or other portion thereof directly involved in such holding or to the person or circumstance therein involved.

SUBCHAPTER 2. EQUAL OPPORTUNITY AND AFFIRMATIVE ACTION OBLIGATIONS OF CONTRACTORS, SUBCONTRACTORS AND CASINO LICENSEES AND APPLICANTS CONCERNING CONSTRUCTION

19:53-2.1 Equal employment and business opportunity obligations of casino licensees and applicants concerning construction

(a) Each casino licensee and applicant shall provide equal employment opportunity to all prospective and actual employees at all levels of the work force and equal business opportunity to all contractors or subcontractors employed in the construction, renovation or reconstruction of the casino hotel, casino, casino simulcasting facility or any related facility.

(b) No architectural plans or site plans of proposed construction, renovation or reconstruction of any structure or facility to be used as a casino hotel, casino, casino simulcasting facility or related facility shall be approved by the Commission, nor shall any contract or subcontract for such work be commenced, unless the casino licensee or applicant requires that, at a minimum, all contracts or subcontracts to be awarded in connection therewith shall contain appropriate provisions by which contractors or subcontractors or their assignees agree to afford:

1. Equal employment opportunity to all prospective employees and actual employees to be employed by the contractor or subcontractor; and

2. Equal business opportunity to all persons who wish to participate in the performance of the contract or subcontract.

(c) Prior to the commencement of any work by a contractor or subcontractor in connection with any construction, renovation or reconstruction of any structure to be used as a casino hotel, casino, casino simulcasting facility or related facility, each casino licensee or applicant shall require the construction contractor or subcontractor to include the mandatory contract language set forth in N.J.A.C. 19:53-2.7 in each contract or subcontract.

(d) No casino license shall issue to or be held by any person unless such person shall demonstrate to the Commission that, as of *[the effective date of these regulations]* ***August 16, 1993***, equal employment opportunity has been afforded, prior to the submission of architectural plans or site plans to the Commission, to all prospective employees and to all actual employees employed by a contractor or subcontractor in connection with the actual construction, renovation or reconstruction of any structure to be used as a casino hotel.

(e) A casino license applicant shall be required to designate an Equal Opportunity Officer in accordance with the provisions of N.J.A.C. 19:53-1.4 prior to the start of actual construction by the applicant or any affiliated entity of any structure or facility to be used as a casino hotel. The casino license applicant shall also be required to submit an EEBOP in accordance with the provisions of N.J.A.C. 19:53-6 prior to *[the earlier of]* the start of actual construction of a casino hotel facility, the recruitment and employment of personnel necessary to undertake the business of the casino or hotel, or the filing of an application for casino licensure***, whichever first occurs***.

19:53-2.2 Obligation of casino licensee or applicant to monitor all construction activity

(a) Unless otherwise specified in the construction section of an approved EEBOP pursuant to N.J.A.C. 19:53-6, each casino licensee or applicant shall be required to develop and implement a monitoring system which allows the casino licensee or applicant to oversee all construction activity performed for the licensee or applicant at the casino hotel, casino, casino simulcasting facility or any related facility.

(b) The monitoring system shall provide for systematic coordination between the equal opportunity officer, the relevant departments within the organization of the casino licensee or applicant which contract for construction work and the purchasing department. The monitoring system shall include, without limitation, procedures which:

1. Ensure that all contractors and subcontractors are notified of their obligation to submit a Project Labor Report pursuant to N.J.A.C. 19:53-2.8 and to confirm that such reports are in fact submitted by comparison of the contractors and subcontractors identified on these reports with those listed on the Project Status Report required pursuant to N.J.A.C. 19:53-2.4;

2. Require the evaluation of the information contained in the Project Labor Reports to ensure their complete, accurate and timely submission, and compliance by all contractors and subcontractors with their obligations under this subchapter;

3. Outline the steps to be used by the casino licensee or applicant to obtain compliance from contractors and subcontractors who fail to fulfill their obligations under this subchapter;

4. Ensure that the mandatory construction contract and subcontract language required by N.J.A.C. 19:53-2.7 is actually included in all construction contracts and subcontracts;

5. Provide notification to all contractors and subcontractors of the obligations of the casino licensee or applicant under the Act and this subchapter;

6. Encourage contractors and subcontractors to employ women and minorities at all levels of the work force;

7. Ensure the documentation of the activities and efforts of contractors and subcontractors to obtain minority and female participation in the construction work force as required by N.J.A.C. 19:53-2.8 and 2.9 when the construction work force of the contractor or subcontractor does not satisfy the women and minority employment goals established by N.J.A.C. 19:53-2.3;

8. Ensure that certified and provisionally certified MBEs and WBEs are afforded equal opportunity to compete in the bidding for construction contracts and subcontracts; and

9. Track the participation of certified and provisionally certified MBEs and WBEs in construction projects.

19:53-2.3 Women and minority employment goals for the construction work force of casino licensees and applicants

(a) Unless otherwise specified in an approved EEBOP pursuant to N.J.A.C. 19:53-6, the women and minority employment goals for the construction work force of a casino licensee or applicant and its individual contractors and subcontractors shall be seven percent for women journeyworkers and apprentices and 22 percent for minority journeyworkers and apprentices.

(b) Subject to the availability of comparable occupational data for Atlantic County concerning levels of employment of women and minorities in the skilled building or construction trades, the Commission may promulgate employment goals for women and minorities in individual skilled building or construction trades. If individual skill or trade goals are promulgated, each specific skill or trade goal shall be used by a casino licensee or applicant, contractor or subcontractor instead of the goals specified in (a) above.

19:53-2.4 Reporting obligations of casino licensees and applicants concerning the construction work force

(a) Unless otherwise specified in the construction section of an approved EEBOP pursuant to N.J.A.C. 19:53-6, each casino licensee or applicant shall be required to file each of the following monthly reports or submissions regarding its construction work force with the Commission ***and Division***:

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1. A Project Labor Report Summary, which shall include all required information contained on each Project Labor Report received by the casino licensee or applicant from contractors or subcontractors pursuant to N.J.A.C. 19:53-2.8 during the preceding month. The Summary shall be submitted in a format prescribed by the Commission and shall be filed by the 15th day of the month.

2. A Project Status Report, which shall describe all construction projects involving contractors or subcontractors which have started or are scheduled to start prior to the filing of the next Project Status Report and shall include: the name and project number for each project; a listing of all contractors and subcontractors working or scheduled to work on each project; the name of any certified or provisionally certified MBE or WBE working or scheduled to work on each project, and the scheduled or actual start date and anticipated finish date of construction. The Project Status Report shall be submitted in a format prescribed by the Commission and shall be filed in accordance with a schedule proposed by the casino licensee or applicant and approved by the Commission; and

3. Copies of all documentation prepared by contractors or subcontractors of activities and efforts to improve minority and female representation, required pursuant to N.J.A.C. 19:53-2.8 or 2.9, and submitted to the casino licensee or applicant during the preceding month. The documentation shall be submitted to the Commission ***and Division*** by the casino licensee or applicant by the 15th day of the month.

(b) Unless otherwise specified in the construction section of an approved EEBOP pursuant to N.J.A.C. 19:53-6, each casino licensee or applicant shall file an Annual Summary of Construction Activity with the Commission and Division at least four months prior to the scheduled date of the EEBOP assessment hearing, initial casino license hearing or casino license renewal hearing. The Annual Summary of Construction Activity shall include a summary of all construction projects started by the casino licensee or applicant during the four calendar quarters immediately preceding the filing deadline for the Annual Summary of Construction Activity. The summary shall, without limitation, describe:

1. The start and actual or anticipated finish date for each construction project;

2. The project number or numbers assigned to each construction project;

3. All contractors and subcontractors providing services on each construction project; and

4. The total dollar amount of construction expenditures made with certified or provisionally certified MBE or WBE construction firms.

19:53-2.5 Special compliance obligations applicable to a casino license applicant building a casino hotel facility

(a) In addition to complying with all of the regulatory requirements of N.J.A.C. 19:53-2.2 which are applicable to a casino license applicant, any casino license applicant which is planning to build or substantially renovate a casino hotel facility prior to licensure shall comply with the requirements of this section and N.J.A.C. 19:53-2.6 in accordance with a schedule to be set by the Commission based on the projected opening date of the casino hotel facility and the hearing schedule of the Commission.

(b) The casino license applicant shall submit a draft affirmative action survey form and draft employment application to the New Jersey Division on Civil Rights (DCR) in accordance with N.J.A.C. 13:7 for review as to their consonance with the rules on pre-employment inquiries and procedures, revise both documents as guided by the review and comments of DCR, and file a copy of the final version of each document and the notice of DCR approval with the Commission.

(c) Notwithstanding the provisions of N.J.A.C. 19:53-4.1, the casino license applicant shall submit for approval by the Commission a description of all hiring criteria and procedures used to determine whether to hire an applicant for employment or to transfer, upgrade or promote an existing employee. Each casino license applicant shall submit the following in *[saisfaction]* ***satisfaction*** of this requirement:

1. A narrative description of the process of screening, interviewing and hiring applicants, which shall include a delineation of the responsibilities of the equal opportunity officer, director of personnel and other principals in that process;

2. A description of any tests, interview procedures or other procedures which will be administered to applicants or employees;

3. A jobs compendium for any positions directly or indirectly related to the construction phase of the casino hotel facility including, without limitation, the equal opportunity officer, the personnel department and the purchasing department;

4. An in-house job posting procedure which shall be a clearly-defined and comprehensively-applied process through which employees may bid for intradepartmental or interdepartmental promotion or transfer;

5. A training summary which shall include information as to the race, gender and job title of those employees who underwent skill enrichment training prior to opening;

6. A summary of the strategies and actual techniques used to hire women and minorities at all levels of the work force;

7. A completed recruitment questionnaire concerning the recruitment process as provided by the Commission;

8. Documentation of contacts with any recruitment sources such as colleges, executive search firms or organizations, and advertisements in minority-oriented and female-oriented media;

9. An in-house complaint procedure for equal employment opportunity complaints to be addressed by the equal opportunity officer; and

10. An employee manual or handbook or other procedure designed to advise all employees of: the policy of the casino license applicant on equal employment opportunity; prohibitions against discrimination and sexual harassment; the name, office location and phone number of the equal opportunity officer; and instructions to contact the equal opportunity officer in the event of an allegation of discrimination or harassment.

19:53-2.6 Special reporting obligations applicable to a casino license applicant building a casino hotel facility

(a) In addition to complying with all of the reporting requirements of N.J.A.C. 19:53-2.4 which are applicable to a casino license applicant, any casino license applicant which is planning to build or substantially renovate a casino hotel facility prior to licensure shall comply with the reporting requirements imposed by this section. These reports shall be filed with the Commission in accordance with a format to be prescribed by the Commission.

(b) An Applicant Flow Report shall identify by gender and race the number of persons who have applied for each job title of the casino license applicant. The report shall include all persons who have applied for a position from the first day the casino license applicant began accepting applications through the date on which the report is prepared. The report shall be submitted in the following two formats:

1. The data shall be sorted by each of the 12 EEOC job categories and subclasses in descending order as defined in N.J.A.C. 19:53-1.3 and, within each job category or subclass, by job title in alphabetical order. Subtotals by EEOC job category or subclass and a total for all 12 EEOC job categories and subclasses shall also be provided.

2. The data shall be sorted by department in alphabetical order and, within each department, by job title in alphabetical order, with the EEOC job category or subclass of each job title indicated adjacent to it. Totals for each department shall also be provided.

(c) A Hired and Pending Report shall identify by gender and race the number of employees who have been hired and the number of applicants to whom an offer to hire was made conditioned upon the opening of the casino hotel. The report shall be submitted in the two formats described in (b)1 and 2 above.

(d) An Employee Information Report shall identify by gender and race the number of employees who are hired and on the payroll of the casino license applicant. After the filing of the initial Employee Information Report, the report shall be submitted by the 15th day of the month following the reporting period.

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19:53-2.7 Construction contracts and subcontracts; mandatory contract language

(a) Every contract or subcontract which concerns the construction of a casino hotel, casino, casino simulcasting facility or any related facility shall contain the following language concerning equal employment opportunity and equal business opportunity:

"During the performance of this contract (or subcontract), the contractor (or subcontractor) agrees that it will be bound by the equal employment and business opportunity requirements of the New Jersey Casino Control Act, N.J.S.A. 5:12-1 et seq., and the rules of the New Jersey Casino Control Commission, N.J.A.C. 19:53.

The contractor (or subcontractor) agrees that it will provide equal employment opportunity, as defined in N.J.A.C. 19:53-1.2, to all prospective and actual employees of the contractor (or subcontractor). The contractor (or subcontractor) agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth in detail the provisions of this equal employment opportunity clause.

The contractor (or subcontractor) agrees that it will include in all advertisements or solicitations for employees placed by or on behalf of the contractor (or subcontractor) a statement that it is an equal employment opportunity employer subject to regulation by the New Jersey Casino Control Commission.

The contractor (or subcontractor) agrees that it will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice advising the labor union or representative of the contractor's (or subcontractor's) commitments under the Casino Control Act and the rules of the Casino Control Commission and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

The contractor (or subcontractor) agrees that it will provide equal business opportunity, as defined in N.J.A.C. 19:53-1.2, to all persons who wish to participate in the performance of the contract (or subcontract). The contractor (or subcontractor) agrees to post in conspicuous places at its place of business and on the project site notices setting forth in detail the provisions of this equal business opportunity clause.

The contractor (or subcontractor) agrees that a representative of the Casino Control Commission and the Division of Gaming Enforcement shall be entitled to attend all construction project meetings and, at reasonable times and in a reasonable manner, to enter the contractor's (or subcontractor's) business facility or facilities or construction project site for determining whether the contractor or subcontractor is complying with the Casino Control Act and the rules of the Commission. The contractor (or subcontractor) agrees that the Commission or the Division, in making such determinations, shall be entitled to inspect or copy any relevant books and records of the contractor (or subcontractor)."

(b) In lieu of the mandatory language required by (a) above, a contractor or subcontractor may include the following language in the contract or subcontract:

"The parties to this contract (or subcontract) agree to incorporate into this contract (or subcontract) the mandatory equal employment and business opportunity contract language contained in the rules of the New Jersey Casino Control Commission at N.J.A.C. 19:53-2.7, as amended or supplemented from time to time, and to comply fully with the terms, provisions and obligations of N.J.A.C. 19:53."

(c) In addition to the contract or subcontract language required by (a) or (b) above, every construction contractor or subcontractor shall also include the following language in every contract or subcontract which concerns the construction of a casino hotel, casino, casino simulcasting facility or any related facility:

"The contractor (or subcontractor) agrees to attempt in good faith to employ women and minority workers in each construction skill or trade consistent with the applicable employment goals established pursuant to N.J.A.C. 19:53-2.3 and to file in a complete, accurate and timely manner all reports and documentation required by the rules of the New Jersey Casino Control Commission."

19:53-2.8 Reporting obligations of construction contractors and subcontractors

***(a)*** Unless otherwise specified in the construction section of an approved EEBOP of a casino licensee or applicant pursuant to N.J.A.C. 19:53-6, each contractor or subcontractor involved in the construction of a casino hotel, casino, casino simulcasting facility or any related facility for that casino licensee or applicant shall be required to file or maintain the following reports or records:

1. A Project Labor Report (PLR) shall be prepared on a weekly basis and shall describe the unionized work force used by the contractor or subcontractor on all construction projects of the casino licensee or applicant during the week. The PLR shall indicate the number of apprentices and journeyworkers employed by the contractor or subcontractor in each skilled building and construction trade and the number of hours each worker, listed by race and gender, was employed during the week. The PLR shall be completed on a form prescribed by the Commission and supplied to the contractor or subcontractor by the casino licensee or applicant. The PLR shall be submitted by the contractor or subcontractor to the equal opportunity officer of the casino licensee or applicant on a schedule established by the casino licensee or applicant which allows inclusion of all PLRs on its Project Labor Report Summary.

i. If a contractor or subcontractor is performing on a construction project where the total cost of the project to the casino licensee or applicant is estimated to be at least two million dollars, the contractor or subcontractor shall be required to submit a PLR which relates solely to that project; all other construction employment by the contractor or subcontractor on projects for that casino licensee or applicant may be reported on a single PLR.

ii. Each casino licensee or applicant shall be required to notify a contractor or subcontractor when a separate PLR is required pursuant to (a)1i above.

2. Documentation shall be maintained of all requests by the contractor or subcontractor to labor unions or other worker representatives to supply qualified women and minorities for employment at casino licensee or applicant construction sites. Copies of this documentation shall be applied to the equal opportunity officer of the casino licensee or applicant.

19:53-2.9 Quarterly assessment of good faith efforts of contractors and subcontractors to meet employment goals for women and minorities; referral to Division

(a) The Commission shall, on a quarterly basis, review and assess the monthly Project Labor Report Summaries submitted by casino licensees or applicants pursuant to N.J.A.C. 19:53-2.4 and any other available documentation concerning the efforts of contractors and subcontractors to meet the applicable employment goals for women and minorities established by N.J.A.C. 19:53-2.3.

(b) Any contractor or subcontractor which fails to meet the applicable employment goals for women and minorities during a calendar quarter***, as measured by the hours of employment reported on the Project Labor Report Summaries of the contractor or subcontractor,*** shall be notified by the Commission that the contractor or subcontractor shall have two additional calendar quarters in which to comply with the goals or document its good faith efforts to do so.

(c) If a contractor or subcontractor which has been notified pursuant to (b) above fails, by the end of the six month compliance review period, to meet the employment goals for women and minorities or to submit documentation of its good faith efforts to meet the goals, the issue of compliance shall be referred to the Division for investigation as to whether a violation of the Act or these rules has occurred. If, upon the filing of a complaint by the Division against a contractor or subcontractor, the Commission finds that a violation has occurred, the contractor or subcontractor may be subject to any of the sanctions enumerated in N.J.S.A. 5:12-129 and N.J.A.C. 19:53-3.5.

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19:53-2.10 Annual report on construction contractor and subcontractor work force of casino licensee or applicant; relation to annual EEBOP assessment

(a) The Commission shall, based on the information derived from the reports required by N.J.A.C. 19:53-2.4(a)1, supply each casino licensee or applicant and the Division with an annual construction contractor and subcontractor work force report for the casino licensee or applicant four months prior to the scheduled date of the EEBOP assessment hearing, initial casino license hearing or casino license renewal hearing of the casino licensee or applicant. The annual construction contractor and subcontractor work force report shall indicate***, based on percentages derived from the hours of employment reported,*** the *[total]* number of apprentices and journeyworkers, listed by race and by gender, employed by the contractors and subcontractors of the casino licensee or applicant in each building skill or construction trade as of the end of the calendar quarter immediately preceding the release date of the annual work force report. Each casino licensee or applicant shall have 30 days from the release date of the report to challenge the information contained therein.

(b) Each casino licensee or applicant whose annual construction contractor and subcontractor work force report does not demonstrate that the casino licensee or applicant achieved the applicable employment goals established by N.J.A.C. 19:53-2.3 for the year shall be required to document its efforts to implement and comply with the construction section of its EEBOP in accordance with the provisions of N.J.A.C. 19:53-6.

SUBCHAPTER 3. EQUAL OPPORTUNITY AND AFFIRMATIVE ACTION OBLIGATIONS OF CASINO SERVICE INDUSTRY ENTERPRISES

19:53-3.1 Designation of equal opportunity officer by casino service industry enterprise licensee; responsibility of chief executive officer and equal employment officer

Each casino service industry enterprise licensee shall designate a principal member of its organization to serve as an equal opportunity officer. The chief executive officer shall be ultimately responsible for insuring that equal employment opportunity is afforded to all prospective and actual employees of the licensee, that equal business opportunity is afforded to all persons who do or would like to do business with the licensee, and that the licensee complies with or makes good faith efforts to comply with any affirmative action obligations imposed on the licensee by the Act and this chapter. The equal opportunity officer shall be directly responsible for the effective and continuing implementation of the equal opportunity and affirmative action obligations of the licensee.

19:53-3.2 Equal employment and business opportunity obligations of all casino service industry enterprise licensees and applicants

(a) Each casino service industry enterprise licensee and applicant shall provide equal employment opportunity to all prospective and actual employees at all levels of its work force.

(b) Each casino service industry enterprise licensee and applicant shall provide equal business opportunity to all persons who do or wish to do business with the licensee or applicant.

(c) The chief executive officer of each casino service industry enterprise licensee or applicant shall submit to the Commission an acknowledgement of the obligations imposed by this section and, if applicable, N.J.A.C. 19:53-3.3, with the application for initial casino service industry licensure, with each application for license renewal, and upon any change in the ownership or management of the casino service industry enterprise.

(d) Each casino service industry enterprise licensee or applicant shall be required to:

1. Post notices available to employees and applicants for employment of the equal employment opportunity obligations of the casino service industry enterprise licensee or applicant; and

2. Include a statement in all postings, advertisements or other solicitations for employment that it is an equal opportunity employer.

19:53-3.3 Affirmative action obligations of casino service industry enterprise licensees and applicants which have 50 or more employees in New Jersey

(a) Each casino service industry enterprise licensee and applicant which employs 50 or more employees in the State of New Jersey shall be required to undertake affirmative measures to ensure that women and minorities are recruited and employed at all levels of its work force and treated during employment without regard to their female or minority status. Such affirmative efforts shall, without limitation, address all employment practices including:

1. Employment, promotion, demotion or transfer;
2. Recruitment, recruitment advertising or posting;
3. Layoff or termination;
4. Rates of pay and other forms of compensation or benefits; and
5. Selection for training programs.

(b) Each casino service industry enterprise licensee and applicant governed by this section shall be required to:

1. Post all employment openings for response by qualified in-house employees or, when appropriate, advertise such openings in newspapers of general circulation and other media which reach a cross-section of the population in the area from which the work force will be drawn;

2. Send notices of employment openings to organizations which serve the interest of promoting equal employment opportunity for women and minorities;

3. Send to each labor union or representative of workers with which it has a collective bargaining agreement a notice of the obligations of the licensee or applicant under the Act and rules of the Commission;

4. Send to each labor union or representative of workers with which it has a collective bargaining agreement a request for referral of qualified women and minority candidates for employment; and

5. Evaluate any criteria, tests, interview procedures and other requirements for employment, promotion and transfer of employees to assure that they are not discriminatory in their impact or that no less discriminatory methods of evaluation or prediction of job performance are feasible.

19:53-3.4 Report by casino service industry enterprise licensees and applicants on the composition of their New Jersey work force

(a) Each casino service industry enterprise license applicant shall submit a statistical report on the composition of its work force in New Jersey at the time of filing of its application for initial licensure.

(b) Each casino service industry enterprise licensee shall submit a statistical report on the composition of its work force in New Jersey with its application for license renewal.

(c) The reports required by (a) and (b) above shall be submitted on forms provided by the Commission and shall indicate the number of employees by race and by gender working in each EEOC job category and subclass.

19:53-3.5 Sanctions

(a) If the Commission determines that a casino service industry enterprise licensee or applicant is in violation of the Act or this subchapter, in addition to any action taken by the Commission to suspend or revoke the casino service enterprise license, the Commission may:

1. Order any or all casino licensees and applicants to terminate or suspend any business relationships or contracts with the casino service industry enterprise licensee or applicant;

2. Prohibit the casino service industry enterprise licensee or applicant from entering into any future contracts with any casino licensee or applicant for a period of time to be determined by the Commission; and

3. Take any other action authorized by the Act or the rules of the Commission.

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SUBCHAPTER 4. EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION OBLIGATIONS OF CASINO LICENSEES AND APPLICANTS CONCERNING THE OPERATIONS WORK FORCE

19:53-4.1 Equal employment opportunity obligations of casino licensees and applicants concerning the operations work force

(a) Each casino licensee and applicant shall provide equal employment opportunity to all prospective and actual employees at all levels of the operations work force.

(b) Each casino licensee and applicant shall be required to:

1. Post notices available to employees and applicants for employment of the equal employment opportunity obligations of the casino licensee or applicant;

2. Include a statement in all postings, advertisements or other solicitations for employment that it is an equal opportunity employer;

3. Post all employment openings for response by qualified in-house employees and, when appropriate, advertise such openings in newspapers of general circulation and other media which reach a cross-section of the population in the area from which the work force will be drawn;

4. Send to each labor union or representative of workers with which it has a collective bargaining agreement, a notice of the obligations of the casino licensee or applicant under the Act and this chapter;

5. Evaluate any criteria, tests, interview procedures and other requirements for employment, promotion or transfer of employees to assure that they are not discriminatory in their impact or that no less discriminatory methods of evaluation or prediction of job performance are feasible;

6. Provide to the Commission, upon request, a description of all criteria, tests, interview procedures or other procedures used to determine whether to employ an applicant for employment or to transfer, upgrade or promote an existing employee; and

7. If necessary, comply with the provisions of (c) below.

(c) In the event that any criteria, test, interview procedure or other employment procedure used by a casino licensee or applicant is shown to have a discriminatory impact, the casino licensee or applicant shall be required to demonstrate to the satisfaction of the Commission that no less discriminatory method of evaluation or prediction of job performance is feasible. In such case, the casino licensee or applicant shall justify the requirements imposed and shall demonstrate to the satisfaction of the Commission that any criteria, tests, interview procedures or other procedures used are truly predictive of job performance. The casino licensee or applicant shall discontinue the use of any criteria, tests, interview procedures or other employment procedures which have a discriminatory impact and which cannot be validated as truly predictive of job performance to the satisfaction of the Commission. In attempting to establish the validity of the criterion, test, interview procedure or other employment procedure, the casino licensee or applicant shall be guided by the rules of the New Jersey Division on Civil Rights and the U.S. Equal Employment Opportunity Commission.

19:53-4.2 Obligations of casino licensees and applicants concerning persons with disabilities; reasonable accommodation

(a) Each casino licensee and applicant shall include in the operations work force section of its EEBOP provisions which address the efforts of the casino licensee or applicant to employ and advance persons with disabilities. Each casino licensee or applicant required to file an EEBOP evaluation with the Commission pursuant to N.J.A.C. 19:53-6 shall include an assessment of the efforts of the casino licensee or applicant concerning persons with disabilities.

(b) Reasonable accommodation in employment to persons with disabilities required of casino licensees or applicants shall be afforded in accordance with the requirements of the Law Against Discrimination, N.J.S.A. 10:5-1 et seq., and attendant regulations, and Title I of the Americans With Disabilities Act of 1990, 42 U.S.C. 12101 et seq., and attendant regulations.

19:53-4.3 Affirmative action obligations of casino licensees and applicants concerning the operations work force

(a) Each casino licensee and applicant shall be required to undertake affirmative measures to ensure that women and minorities are recruited and employed at all levels of the operations work force and treated during employment without regard to their female or minority status. Such affirmative efforts shall, without limitation, address all employment practices including:

1. Employment, promotion, demotion or transfer;

2. Recruitment, recruitment advertising or posting;

3. Layoff or termination;

4. Rates of pay and other forms of compensation or benefits; *[and]*

5. Selection for training programs*[.]***; and***

***6. Grievance procedures for, and disposition of, complaints related to equal employment opportunity.***

(b) Each casino licensee and applicant shall:

1. Post or advertise all personnel transactions which result in a promotion, title change/reclassification or a new hire prior to the selection of a candidate;

2. Undertake efforts to improve the representation of women and minorities in job titles within EEOC job categories in which the casino licensee is below the applicable employment goals established by N.J.A.C. 19:53-4.4;

3. Undertake special recruitment and advancement efforts beyond posting and advertising positions in newspapers of general circulation to improve the representation of women and minorities in positions with salaries equal to or greater than $35,000, such as the use of search firms, advertisements in women-oriented and minority-oriented media, and notices to organizations which serve the interests of women and minorities;

4. Maintain and submit statistics on the applicant flow and disposition of women and minority candidates for employment who are interviewed or referred, and provide documentation of postings, classified advertisements, and other media used to seek candidates;

5. Develop and implement upward mobility training programs, approved by the Commission, which are designed to increase women and minority representation in EEOC job categories, including subclasses of Officials and Managers, in which the casino licensee or applicant is below the applicable employment goal for the category;

6. Improve the representation of women and minorities in positions covered by collective bargaining agreements in which the casino licensee or applicant is below the applicable employment goal for the category by complying with the provisions of (c) below.

(c) If a casino licensee or applicant is below the applicable employment goal for women or minorities established by N.J.A.C. 19:53-4.4 for a position covered by a collective bargaining agreement, the casino licensee or applicant shall, without limitation:

1. Request in writing that the union or workers representative refer qualified female or minority candidates, as appropriate, for the position in question; and

2. If the union or workers representative is unable to refer an appropriate woman or minority candidate, the casino licensee or applicant shall advertise the position on the open market and document its efforts to hire a qualified female or minority candidate for the position. This documentation shall include, without limitation, statistics on applicant flow, details on referrals received, disposition of candidates interviewed, letters of request to the union or workers representative, and copies of postings and advertisements.

19:53-4.4 Women and minority employment goals for the operations work force of casino licensees and applicants

(a) Unless otherwise specified in an approved EEBOP pursuant to N.J.A.C. 19:53-6, the women and minority employment goals for the operations work force of a casino licensee or applicant shall be 46 percent for women and 22 percent for minorities for each EEOC job category except craftpersons, which shall be subject to the applicable women or minority employment goal established pursuant to N.J.A.C. 19:53-2.3.

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(b) Subject to the availability of comparable occupational data for Atlantic County concerning levels of employment of women and minorities in the eight EEOC job categories other than craftpersons, the Commission may promulgate employment goals for women and minorities for each of these eight EEOC job categories. If job category goals are promulgated, each specific job category goal shall be used by a casino licensee or applicant instead of the goals specified in (a) above.

19:53-4.5 Quarterly report on the affirmative action efforts of casino licensees concerning the operations work force

(a) Beginning with the first calendar quarter after the opening of its casino, each casino licensee shall be required to file a quarterly report with the Commission and the Division on its affirmative action efforts concerning its operations work force. The quarterly report shall be presented in a format approved by the Commission and shall be filed by the fifteenth day of the month following the end of the quarter.

(b) The quarterly report shall provide data concerning the composition of the operations work force of the casino licensee and shall list by race and by gender the number of workers employed by the casino licensee in each EEOC job category and subclass.

(c) The quarterly report shall include the following information concerning new hires and promotions by the casino licensee in positions with a salary of $35,000 or more:

1. The number of new hires and promotions by job title, race and gender; and

2. If the casino licensee is below the applicable women or minority employment goal established by N.J.A.C. 19:53-4.4 for a job category in which a position with a salary of $35,000 or more is filled by someone other than a woman or minority, the casino licensee shall document its efforts to hire or promote a woman or minority to the position. Such documentation shall include a completed and signed Affirmative Action Impact Statement and copies of any posting, advertisement, and letters to search firms, unions, and other organizations which were prepared during the hiring or promotion process.

(d) The quarterly report shall also include:

1. A summary of new hires, promotions, involuntary and voluntary terminations and layoffs by EEOC job category;

2. A copy of all grievance reports related to equal employment opportunity filed with the casino licensee's equal opportunity officer; and

3. A report on the implementation of all upward mobility training programs and the status of participants.

19:53-4.6 Annual report by casino licensee or applicant on the composition of its operations work force; relation to annual EEBOP assessment

(a) Each casino license applicant shall submit a statistical report on the composition of its operations work force at the time of filing its application for initial casino licensure. Thereafter, the applicant shall file the report four months prior to the scheduled date of its EEBOP assessment hearing or its initial casino license hearing.

(b) Each casino licensee which, pursuant to the provisions of N.J.A.C. 19:53-6.12, was not required to file a quarterly report for the last calendar quarter which ended at least four months prior to the scheduled date of its EEBOP assessment hearing or casino license renewal hearing, shall submit a statistical report on the composition of its operations work force at least four months prior to the scheduled date of such hearing.

(c) The reports required by (a) and (b) above shall be submitted in a form prescribed by the Commission and shall indicate the number of employees by race and by gender working in each EEOC job category as of, except for the initial report submitted by a casino license applicant, the end of the calendar quarter immediately preceding the filing deadline for submission of the report.

(d) Each casino licensee or applicant whose annual operations work force composition report does not demonstrate that the casino licensee or applicant achieved the applicable employment goals established by N.J.A.C. 19:53-4.4 for the year shall be required to document its efforts to implement and comply with the operations work force section of its EEBOP in accordance with the provisions of N.J.A.C. 19:53-6.

SUBCHAPTER 5. EQUAL BUSINESS OPPORTUNITY AND AFFIRMATIVE ACTION OBLIGATIONS OF CASINO LICENSEES AND APPLICANTS

19:53-5.1 Background and general purposes

(a) As described more fully in subsection 1b of the Act, N.J.S.A. 5:12-1b, the central underlying purpose of the Act is to channel the economic and social impact from the legalization of casino operations in Atlantic City into the rebuilding and growth of the economy of the local area. More specifically, the Act is designed to: generate resources that permit the redevelopment of blighted areas of Atlantic City, including stabilizing residential neighborhoods; create job opportunities for city residents and others in both casino hotels and casino-related service companies; and encourage the development of visitor, convention and tourism facilities in Atlantic City that will provide employment and business opportunities for local residents.

(b) The Act is further designed to permit and encourage as many businesses as possible to service the casino industry, both for the purpose of expanding investment and job opportunities in the area and in order to encourage competition and a plentiful supply of available goods and services to the industry, so as to insulate it from risks of economic instability and undue economic concentrations.

(c) At the time of enactment of the Act a significant portion of the population of Atlantic City was comprised of minorities, as defined in this chapter. In recognition of this fact, the Act provides specific guidelines and policies designed to assure that the aforementioned public policies would be administered so as to direct the attention and resources of the Commission to addressing the needs of the minority community. N.J.S.A. 5:12-134 and 135. The clear purpose of the Act is to guarantee the opportunity for all, without disadvantage by reason of race, gender or ethnicity, to participate fully in the economic and social benefits that are generated by the development of the casino industry. According to the most recent census data, a large majority of the residents of Atlantic City are minorities. Therefore, the premise of the statute remains a compelling reality, and any program designed to provide or improve opportunities for the residents of Atlantic City must of necessity address the need to prevent or eliminate any disadvantage incurred by reason of race or ethnicity.

(d) The Act makes clear that casino licensure is a revocable, and in many ways unique, privilege, and that such a license is held conditioned upon compliance with all regulations that are designed to further the purposes of the Act. Indeed, in recognition of this obligation, and in keeping with the manifest design of the Act, the casino licensees collectively entered into a voluntary agreement in 1981, under the terms of which they undertook to guarantee that 15 percent of their spending for goods and services would enure to the benefit of minority business enterprises. Notwithstanding the generalized good faith attempts by the casino industry over the years, this goal has not yet been realized, due largely, according to evidence presented to the Commission, to the many problems associated with new and developing minority enterprises, including, without limitation, racial discrimination; difficulties in attracting equity or other capital funds; inability to secure bonding or meet other job requirements as a result of insufficient ability to document prior satisfactory job completions; relative lack of experienced minority managerial personnel, and the existence of extensive commercial relationships of long standing which many casino licensees are reluctant to endanger.

(e) The comparative success of the casino industry in meeting employment goals for minorities and women suggests that a targeted program that establishes specific goals for business opportunities for minority and woman business enterprises, but affords significant flexibility to the casino licensees in determining new and innovative methods for assisting such enterprises to compete effectively, is an appropriate means to assure the realization of the purposes of the

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Act and the goals of the voluntary agreement of 1981, and the achievement of both the fact and the appearance of equal opportunity for all people.

19:53-5.2 Equal business opportunity obligation of all casino licensees and applicants

Each casino licensee and applicant shall afford equal business opportunity to all persons who do or wish to do business with the licensee or applicant in connection with its casino hotel, casino, casino simulcasting facility or any related facility.

19:53-5.3 Participation goals for casino licensee purchases of goods and services from minority and women businesses

(a) Beginning on the date of receipt of its casino license, every casino licensee shall make a good faith effort to spend each year at least five percent of the dollar value of its contracts for goods and services, calculated in accordance with the provisions of N.J.A.C. 19:53-5.5, with certified and provisionally certified MBEs and WBEs.

(b) Effective January 1, 1991, or three years after the receipt of its casino license, whichever is later, every casino licensee shall make a good faith effort to spend each year at least 10 percent of the dollar value of its contracts for goods and services, calculated in accordance with the provisions of N.J.A.C. 19:53-5.5, with certified and provisionally certified MBEs and WBEs.

(c) Effective January 1, 1994, or six years after the receipt of its casino license, whichever is later, every casino licensee shall make a good faith effort to spend each year at least 15 percent of the dollar value of its contracts for goods and services, calculated in accordance with the provisions of N.J.A.C. 19:53-5.5, with certified and provisionally certified MBEs and WBEs.

(d) Every casino licensee shall make a good faith effort, considering the availability of both groups, to distribute the dollar value of its contracts for goods and services equitably between:

1. Certified and provisionally certified MBEs; and
2. Certified and provisionally certified WBEs.

19:53-5.4 Provisional certification of minority and women businesses

(a) An enterprise may qualify for provisional certification as an MBE, a WBE, or both.

(b) In order to qualify for provisional certification as an MBE or WBE, an enterprise must be independently owned, operated and controlled. An enterprise shall be deemed to be independently owned, operated or controlled if its management is responsible for both its daily and long term operation and owns at least 51 percent of the enterprise.

(c) In order to qualify for provisional certification as an MBE, an enterprise must be:

1. A sole proprietorship owned and controlled by a minority; or
2. A partnership or joint venture owned and controlled by minorities in which at least 51 percent of the ownership interest is held by minorities and the management and daily business operations are controlled by one or more of the minorities who own it; or
3. A corporation or other business entity authorized under the laws of the United States whose management and daily business operations are controlled by one or more minorities who own it, and which is at least 51 percent owned by one or more minorities or, if stock is issued, at least 51 percent of the stock is owned by one or more minorities.

(d) In order to qualify for provisional certification as a WBE, an enterprise must be:

1. A sole proprietorship owned and controlled by a woman; or
2. A partnership or joint venture owned and controlled by women in which at least 51 percent of the ownership interest is held by women and the management and daily business operations are controlled by one or more of the women who own it; or
3. A corporation or other business entity authorized under the laws of the United States whose management and daily business operations are controlled by one or more women who own it, and which is at least 51 percent owned by one or more women or, if stock is issued, at least 51 percent of the stock is owned by one or more women.

(e) Any enterprise which meets the requirements in (b) and either (c) or (d) above shall be provisionally certified by the Commission if the enterprise files an affidavit with the Commission, in a form provided by the Commission, attesting that it is a bona fide MBE or WBE. The affidavit shall be accompanied by a written acknowledgement of the penalties which may be imposed on the enterprise and the persons associated therewith pursuant to (i) below if the enterprise makes any material misrepresentation of fact in its application for certification or provisional certification.

(f) Upon filing of the documents required in (e) above, the enterprise shall be notified that it has been provisionally certified and shall be listed in the Commission's directory of certified and provisionally certified MBEs and WBEs (Commission MBE/WBE Directory).

(g) A provisionally certified MBE or WBE shall be required to complete and submit to the Commission or the DCED an application for DCED certification in accordance with the provisions of N.J.A.C. 12A:11 within 60 days from the date of notice of its provisional certification. The Commission shall provide assistance to MBEs and WBEs in applying for certification by the DCED. In the event that a completed application for DCED certification is not filed within 60 days, the MBE or WBE shall lose its provisional certification and shall be removed from the Commission MBE/WBE Directory.

(h) Any provisional certification of an enterprise granted by the Commission pursuant to this section shall automatically terminate upon a final decision by the DCED on the certification application of the enterprise pursuant to N.J.A.C. 12A:11. The revised status of the enterprise shall be reflected in the Commission MBE/WBE Directory.

(i) If it is determined by the Commission or the DCED, upon the denial of certification by the DCED, or at any time before or after such decision, that an enterprise has intentionally misrepresented material facts on the affidavit required pursuant to (e) above or in its application for DCED certification, the Commission, after an appropriate hearing pursuant to N.J.A.C. 19:42, shall remove the enterprise from the Commission MBE/WBE directory. In addition, the Commission may prohibit any such enterprise from transacting further business with any casino licensee or applicant for a period of five years. Such prohibition may be applied to all owners, principals, officers and employees of the enterprise.

(j) Certification or provisional certification of an enterprise as an MBE or WBE does not in any way relieve that enterprise or any casino licensee of its obligation to comply with any requirement of the Act or the Commission's rules concerning registration or licensure of enterprises doing business with casino licensees.

19:53-5.5 Determination of casino licensee net disbursements for goods and services and disbursements to MBEs and WBEs

(a) In determining the net disbursements for goods and services made by a casino licensee during any period and the percentage thereof made with certified and provisionally certified MBEs and WBEs, a casino licensee shall first record the amount of its gross disbursements during the period, including bus business, and then determine its adjusted gross disbursements by deducting its allowable administrative costs and allowable direct labor costs for the period.

(b) Allowable administrative costs are defined as follows:

1. Fees paid to governmental and quasi-government organizations such as fees paid to the Commission, the Athletic Control Board, the Securities and Exchange Commission, the Department of Motor Vehicles, and the Alcoholic Beverage Control Board; payments made to the United States Post Office for the cost of postage; court costs; and Department of Community Affairs permit and license fees;
2. Refunds paid to customers; cash awards and settlements; room deposit refunds; and casino licensee donations to charities recognized by the Internal Revenue Service;
3. Dues and fees for professional associations, trade publications and journals; and
4. Reimbursements for employee travel, food and lodging. This deduction shall not include the cost of conferences, expositions and seminars.

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(c) Allowable direct labor costs are defined as follows:

1. Net payroll, which is the cost of salaries, wages, overtime, cash bonuses, director's fees and incentive pay; and

2. Payments related to: workman's compensation claims; payments for employee benefits packages such as 401k contributions and other withholdings such as credit union deductions and employee charitable deductions; payments made to employee wage garnishment agencies pursuant to a court order; and union fees and dues including membership dues, health and welfare, pension, severance, education, legal and annuity fund payments.

(d) The total cost of the following disbursements shall then be deducted from adjusted gross disbursements to determine net disbursements for the period:

1. Utilities and taxes;

2. Financing costs, such as mortgages, loans or any other type of debt;

3. Medical insurance paid directly by the casino licensee on behalf of its employees which, for the purposes of determining net disbursements, shall not include any other insurance such as general or property liability insurance aviation, auto or crime insurance;

4. Dues and fees to the Casino Association of New Jersey and Central Credit of New Jersey, Inc.;

5. Fees and payments to a parent or affiliated company of the casino licensee other than those that represent fees and payments for goods and services supplied by non-affiliated persons through an affiliated company for the use or benefit of the casino licensee; and

6. Rents paid for real property and any payments constituting the price of an interest in real property as a result of a real estate transaction which, for the purposes of determining net disbursements, shall not include fees paid incidental to the real estate transaction, such as fees for brokers who represent the casino licensee, finder's fees, title insurance or other insurance.

(e) A casino licensee may fulfill up to 70 percent of the MBE and WBE participation goals established by N.J.A.C. 19:53-5.3, or any part thereof, by requiring contractors to award portions of their contracts to certified and provisionally certified MBEs and WBEs, to the extent that dollars are actually spent with certified and provisionally certified MBEs and WBEs. In determining the good faith efforts of a casino licensee to meet its MBE and WBE participation goals, no consideration shall be given to dollars spent by casino contractors with certified and provisionally certified MBEs and WBEs in excess of this 70 percent limitation. Any casino licensee seeking credit for subcontracts awarded to certified or provisionally certified MBEs or WBEs by a casino contractor shall provide proof of the amount of the disbursements to the Commission. Such proof shall include:

1. Executed copies of the contract and subcontract;

2. Copies of any payment orders and checks made payable to the certified or provisionally certified MBE or WBE subcontractor or copies of computer generated records which indicate that such payments were made; and

3. Any other information the Commission may require concerning the circumstances of a particular contract or subcontract.

(f) The percentage of disbursements awarded to certified and provisionally certified MBEs and WBEs by a casino licensee during any period shall be determined by dividing the total amount of such disbursements made during the period by the casino licensee and by any contractor pursuant to an agreement authorized under (e) above, by the net disbursements of the casino licensee for the period as determined in (a) and (d) above.

(g) When recording or reporting the dollar value of its disbursements for goods or services with MBEs and WBEs, a casino licensee shall record or report a disbursement with an enterprise that has been certified as both an MBE and WBE only once. If a casino licensee has an agreement with a contractor in which the contractor agrees to award a portion of its contract to certified or provisionally certified MBEs or WBEs pursuant to (e) above and the contractor itself is a certified or provisionally certified MBE or WBE, a casino licensee shall not claim credit for any disbursement to the certified or provisionally certified MBE or WBE subcontractor if a corresponding credit is claimed for the casino contract.

19:53-5.6 Valuation of casino licensee disbursements for bus business

(a) When determining the amount of gross disbursements or net disbursements made by a casino licensee during any period, the total dollar value of the bus business to be reported by the casino licensee during the period, for the purposes of this subchapter, shall be determined by totalling all direct and indirect payments made to bus owners or operators by the casino licensee during the period.

(b) The amount of bus business to be reported pursuant to this section shall be equal to the value of the direct or indirect compensation provided to the bus owner or operator by the casino licensee. Examples of compensated bus business which must be reported pursuant to this section shall include, without limitation, arrangements whereby:

1. The casino licensee directly charters and pays for the use of the bus;

2. The casino licensee indirectly pays for the use of the bus by reimbursing the user of the bus specifically for the cost of transportation;

3. The casino licensee reimburses a third party for providing the bus for the use of other persons; or

4. The casino licensee pays for the cost of advertising or other goods and services which directly benefit the owner or operator of the bus.

(c) The amount of bus business to be reported pursuant to this section shall not include arrangements whereby a casino licensee agrees to provide complimentary goods or services to the passengers of a bus owner or operator in exchange for the promise of the bus owner or operator to bring its passengers to the casino hotel facility of the casino licensee.

(d) When recording or reporting the dollar value of its bus business, a casino licensee may record or report monies spent with an enterprise that has been certified as both an MBE and a WBE only once.

19:53-5.7 Quarterly casino licensee disbursement reports

(a) Each casino licensee shall submit to the Commission and the Division, in a format prescribed by the Commission, a quarterly report on its purchases of goods and services, including bus business, which shall consist of the following information recorded in accordance with the requirements of N.J.A.C. 19:53-5.5:

1. The total dollar value of gross disbursements;

2. The total dollar value of allowable administrative costs, as defined in N.J.A.C. 19:53-5.5, deducted from gross disbursements;

3. The total dollar value of allowable direct labor costs, as defined in N.J.A.C. 19:53-5.5, deducted from gross disbursements;

4. The total dollar value of adjusted gross disbursements for goods and services made by the casino licensee during the quarter;

5. The total dollar value of net disbursements for goods and services made by the casino licensee during the quarter;

6. The name and vendor identification number of each certified and provisionally certified MBE or WBE with whom the casino licensee did business during the quarter, as well as:

i. The certification status of the enterprise (MBE or WBE);

ii. The total dollars disbursed to the enterprise; and

iii. The total amount of dollars, if any, which were disbursed to the certified or provisionally certified MBE or WBE by a contractor pursuant to an agreement as described in N.J.A.C. 19:53-5.5(e);

7. The total dollar amount of disbursements made to certified and provisionally-certified MBEs and WBEs during the quarter by either the casino licensee or its contractors, listed by MBEs, WBEs and combined total, and the percentage of the net disbursements reported pursuant to (a)5 above that each listed amount represents; and

8. The total dollar amount of disbursements made during the quarter to certified and provisionally-certified MBEs and WBEs by contractors pursuant to agreements as described in N.J.A.C. 19:53-5.5(e).

(b) The quarterly reports required by this section shall be based on calendar quarters and shall be filed with the Commission and the Division by the last business day of the month following the expiration of the calendar quarter. The initial quarterly report of

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any casino licensee which receives its casino license on a date other than the beginning of the calendar quarter shall be based on the partial calendar quarter.

19:53-5.8 Annual report by casino licensees on disbursements to WBEs and MBEs; relation to annual EEBOP assessment

(a) Each casino licensee shall file an annual MBE/WBE disbursement report with the Commission and Division at least four months prior to the scheduled date of its EEBOP assessment hearing or casino license renewal hearing. The annual MBE/WBE disbursement report shall contain a yearly summary of the information required by N.J.A.C. 19:53-5.7(a)1 through 5, 7 and 8 for the four calendar quarters immediately preceding the filing deadline for the annual MBE/WBE disbursement report.

(b) Each casino licensee whose annual MBE/WBE disbursement report does not demonstrate that the casino licensee achieved the applicable participation goals specified in N.J.A.C. 19:53-5.3 shall be required to document its good faith efforts to implement and comply with the business section of its EEBOP in accordance with the provisions of N.J.A.C. 19:53-6.

19:53-5.9 Required reporting adjustments for enterprises removed from the Commission MBE/WBE Directory

(a) A casino licensee shall be required to report separately in the MBE or WBE disbursement sections of its current quarterly disbursement report, required pursuant to N.J.A.C. 19:53-5.7, or its current annual disbursement report, required pursuant to N.J.A.C. 19:53-5.8, any disbursement made to a certified or provisionally certified MBE or WBE which is removed from the Commission MBE/WBE Directory prior to the submission of the report to the Commission and the Division.

(b) In determining the good faith efforts of a casino licensee to implement and comply with the provisions of its approved EEBOP pursuant to N.J.A.C. 19:53-6.8, a casino licensee may receive credit for any disbursement made to an MBE or WBE which was certified or provisionally certified at the time of the disbursement even if such enterprise is subsequently removed from the Commission MBE/WBE Directory unless the casino licensee knew or should have known at the time of the disbursement that the MBE or WBE did not qualify for certification.

(c) Any disbursement to an MBE or WBE which is removed from the Commission MBE/WBE Directory during the current reporting period shall not be included in any report prepared by the Commission or any casino licensee concerning actual disbursements made to certified or provisionally certified MBEs and WBEs.

SUBCHAPTER 6. COMPLIANCE BY CASINO LICENSEES AND APPLICANTS—PREPARATION, IMPLEMENTATION AND REVIEW OF EQUAL EMPLOYMENT AND BUSINESS OPPORTUNITY PLAN (EEBOP)

19:53-6.1 Equal Employment and Business Opportunity Plan (EEBOP); purpose and basic elements

(a) In order to insure compliance with the requirements of section 134 of the Act and this chapter, each casino licensee and applicant shall be required to submit an Equal Employment and Business Opportunity Plan (EEBOP) to the Commission for its approval. The EEBOP of each casino licensee or applicant shall address in specific terms the strategies, procedures and internal requirements which the casino licensee or applicant intends to implement so that the equal employment opportunity, equal business opportunity and affirmative action objectives and goals of the Act and this chapter are achieved, both on a current and continuing basis.

(b) Each casino licensee or applicant shall be encouraged to use imagination and innovation in the development of its EEBOP. Although, in general, no particular format will be required, every EEBOP prepared by a casino license applicant shall include Sections, at a minimum, addressing the first three basic subject matter areas listed below, and every EEBOP prepared by a casino licensee shall contain sections addressing each of the following areas:

1. General regulatory requirements;
2. Construction requirements;
3. Operations work force requirements; and
4. Business requirements.

(c) The EEBOP of a casino license applicant which will be building or substantially renovating a casino hotel facility prior to licensure shall address all phases of the development of the project including planning and feasibility studies in preparation for initial construction.

19:53-6.2 General regulatory section of an EEBOP

(a) Every EEBOP submitted by a casino licensee or applicant shall include, at a minimum, the following:

1. A statement by the chief executive officer of the casino licensee or applicant setting forth the equal employment and business opportunity policies of the organization;
2. An acknowledgement by the chief executive officer of the obligations imposed by section 134 of the Act and this chapter; and
3. A description of the means by which the policies of the casino licensee or applicant concerning equal opportunity and affirmative action shall be disseminated and enforced including, without limitation, orientation or training sessions for staff as well as management, placement and supervisory personnel; the availability of the EEBOP to staff for review; and the inclusion of accountability for achieving the objectives of this chapter and the EEBOP of the casino licensee or applicant in the performance evaluations of executives, managers and supervisors.

(b) Other topics appropriate for inclusion in the general regulatory section of an EEBOP shall include, without limitation, the following:

1. A delineation of the role and responsibilities of the equal opportunity officer and his or her staff;
2. A description of the lines of communication and reporting within the organization as they relate to the objectives of this chapter; and
3. A description of the procedures and techniques which the casino licensee or applicant will use to monitor implementation of the EEBOP and to assess the need for modifications.

19:53-6.3 Construction section of an EEBOP

(a) The construction section of an EEBOP prepared by a casino licensee or applicant shall describe in detail the means by which the licensee or applicant intends to comply with the equal opportunity and regulatory obligations imposed by N.J.A.C. 19:53-2. Topics appropriate for inclusion in the construction section of an EEBOP shall include, without limitation, the following:

1. Coordination and communication in the implementation of construction plans by the equal opportunity officer, the executive office, the facilities department, the purchasing department, and any other appropriate department;
2. Implementation of a monitoring system which will enable the casino licensee or applicant to evaluate the performance of contractors and subcontractors and the performance of the licensee's or applicant's own organization in fulfilling the reporting and documentation requirements imposed by this chapter; and
3. Procedures and penalties to be used by the casino licensee or applicant if a contractor or subcontractor does not fulfill its goal, documentation or reporting requirements.

(b) If a casino licensee or applicant has failed to achieve the contractor and subcontractor employment goals for women and minorities established pursuant to N.J.A.C. 19:53-2.3, topics appropriate for inclusion in the construction section of an EEBOP may also include, without limitation, the following:

1. Innovative strategies for increasing the participation of women and minorities in the construction work force and the utilization of certified and provisionally certified MBEs and WBEs as contractors and subcontractors, assuming that forecasted capital expenditures remain level; and
2. Specific objectives and timetables for the implementation of the strategies described pursuant to (b)1 above.

19:53-6.4 Operations work force section of an EEBOP

(a) The operations work force section of an EEBOP prepared by a casino licensee or applicant shall describe in detail the means by which the licensee or applicant intends to comply with the equal opportunity and regulatory obligations imposed by N.J.A.C. 19:53-4.

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Topics appropriate for inclusion in the operations work force section of an EEBOP shall include, without limitation, the following:

1. Coordination and communication in the personnel practices of the casino licensee or applicant by the equal opportunity officer, the executive office, the personnel department, and any other appropriate department;

2. The means by which the casino licensee or applicant shall address its obligation to provide equal employment opportunity and reasonable accommodation in employment to persons with disabilities in accordance with the requirements of N.J.A.C. 19:53-4.2; and

3. The means by which the casino licensee or applicant will insure that all required reports are completed and filed when due.

(b) If a casino licensee or applicant has failed to achieve the employment goals for women and minorities in the operations work force established pursuant to N.J.A.C. 19:53-4.4, topics appropriate for inclusion in the operations work force section of an EEBOP may also include, without limitation, the following:

1. Strategies and measurable objectives for improving the employment of women and minorities in each EEOC job category in which they are underrepresented including, without limitation, proactive initiatives in the following areas:

i. Recruitment, advertising, posting, use of referral agencies and search firms;

ii. Employment;

iii. Training, development or promotion;

iv. Retention; and

v. Lay off, discipline or terminations;

2. Timetables for achievement of the EEBOP objectives;

3. Strategies to improve the representation of women and minorities in positions with salaries of $35,000 or more;

4. Recruitment resources, including agencies, publications, and groups which serve the interests of women and minorities;

5. Procedures for handling complaints concerning equal employment opportunity or sexual harassment and the means by which employees are advised of the procedures;

6. Efforts to eliminate racial or gender disparities in turnover rates among employees;

7. The use of exit interviews or other means to assess why employees leave on a voluntary basis;

8. Efforts to improve employee retention; and

9. Development and implementation of internal monitoring and analysis mechanisms to be used to review, evaluate and, if needed, correct plan progress.

19:53-6.5 Business section of an EEBOP

(a) The business section of an EEBOP prepared by a casino licensee shall describe in detail the means by which the licensee intends to comply with the equal business opportunity and regulatory obligations imposed by N.J.A.C. 19:53-5. Topics appropriate for inclusion in the business section of an EEBOP shall include, without limitation, the following:

1. Coordination and communication in the purchasing practices of the casino licensee by the equal opportunity officer, the executive office, the purchasing department and any other appropriate department; and

2. The means by which the casino licensee will insure that all of its disbursements are recorded in accordance with the requirements of N.J.A.C. 19:53-5.5 and 5.6 and reported in a timely manner.

(b) If a casino licensee has failed to achieve the participation goals for goods and services to be purchased from certified or provisionally certified minority and women businesses established pursuant to N.J.A.C. 19:53-5.3, topics appropriate for inclusion in the business section of an EEBOP may also include, without limitation, the following:

1. An analysis of the goods and services which are anticipated to be purchased by the casino licensee and the types of goods and services which might be purchased from certified and provisionally certified MBEs and WBEs based on availability;

2. Strategies and initiatives to be undertaken by the casino licensee to assist certified and provisionally certified MBEs and WBEs to compete, survive and grow in casino contracting and purchasing, which may include, without limitation, any efforts by the casino licensee to:

i. Assist MBEs and WBEs to apply for certification;

ii. Assist MBEs and WBEs to qualify for appropriate contracts;

iii. Provide assistance to MBEs and WBEs in seeking out financial sources for expansion, renovation or upgrading of products or services;

iv. Provide technical or financial assistance to MBEs and WBEs in seeking out bonding services, underwriting a bond, or waiving a bonding requirement to enable them to qualify for appropriate contracts;

3. Mentoring and other appropriate business development activities which may, without limitation, include:

i. Loaned executive programs;

ii. Provision of on-the-job trainers for specific functional areas of business, such as computers or personnel administration; and

iii. The loaning of equipment or services, such as computers, secretarial or data processing services;

4. The means by which the casino licensee will provide notice to certified and provisionally certified MBEs and WBEs of its intent to purchase goods or services;

5. Procedures which the casino licensee will use to document its good faith efforts to utilize the services of certified and provisionally certified MBEs and WBEs, such as documentation of affirmative efforts by the licensee to:

i. Increase financial assistance to certified and provisionally certified MBEs and WBEs through the use of low-cost loans;

ii. Develop special payment terms for certified and provisionally certified MBEs and WBEs;

iii. Contribute to local or regional Minority Enterprise Small Business Investment Corporations (MESICs);

iv. Encourage joint ventures between certified and provisionally certified MBEs and WBEs and majority-owned businesses or joint ventures with other certified and provisionally certified MBEs and WBEs;

v. Provide technical assistance and mentoring; and

vi. Develop incentives for majority contractors to subcontract to certified and provisionally certified MBEs and WBEs, and to retain and sustain certified and provisionally certified MBEs and WBEs vendors through encouragement and development activities; and

6. Programs, consistent with N.J.A.C. 19:53-5.5, which require contractors to subcontract a portion of their contracts to certified or provisionally certified MBEs and WBEs.

19:53-6.6 Atlantic City small businesses

(a) In order to further the statutory goal of revitalizing Atlantic City as set forth in section 1 of the Act, each casino licensee and applicant shall be encouraged to include in its EEBOP strategies and objectives which are intended to foster the development of Atlantic City small businesses. For the purposes of this section, an "Atlantic City small business" shall be defined as a sole proprietorship, partnership or corporation whose management owns at least 51 percent of the business and is responsible for its daily and long-term operation, has 50 or fewer full-time employees and has its principal place of business (the location where the majority of its employees are located or based) in Atlantic City.

(b) Casino licensees and applicants are encouraged to assist Atlantic City small businesses by using the same kinds of techniques described in N.J.A.C. 19:53-6.5 or any other means deemed appropriate by the licensee or applicant.

(c) Any enterprise which meets the requirements in (a) above may be certified by the Commission as an Atlantic City small business if it files an application and affidavit with the Commission, in a form provided by the Commission, attesting that it is a bona fide Atlantic City small business. The affidavit shall be accompanied by a written acknowledgement of the penalties which may be imposed on the enterprise and the persons associated therewith if the enterprise makes any material misrepresentation of fact in its affidavit or application for certification. Any enterprise which misrepresents its status as an Atlantic City small business shall be subject to the same penalties set forth in N.J.A.C. 19:53-5.4(i).

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(d) The Commission shall maintain a section in its directory of certified and provisionally certified MBEs and WBEs which lists all certified Atlantic City small businesses. An enterprise may be certified as both an MBE and WBE and an Atlantic City small business.

19:53-6.7 EEBOP filing requirements; review and approval; revisions

(a) Any entity which is an applicant for or holds a casino license as of *[the effective date of this chapter]* ***August 16, 1993*** shall file its initial EEBOP with the Commission and Division *[within 120 days of the effective date of this chapter]* ***by December 14, 1993***. All other casino license applicants shall file an EEBOP prior to *[the earlier of]* the start of actual construction of a casino hotel facility, the recruitment and employment of personnel necessary to undertake the business of the casino or hotel, or the filing of an application for casino licensure***, whichever first occurs***.

(b) After initial approval by the Commission, a casino licensee or applicant shall not be required to resubmit all or any part of the EEBOP for review or approval unless:

1. The EEBOP is voluntarily revised by the licensee or applicant pursuant to (c) below;

2. The Commission directs that the EEBOP be revised as a result of an annual EEBOP assessment hearing pursuant to N.J.A.C. 19:53-6.8; or

3. The Commission directs that the EEBOP be revised as a result of a special review of the EEBOP ordered pursuant to N.J.A.C. 19:53-6.9.

(c) A casino licensee or applicant may request the approval of the Commission to revise its EEBOP at any time. No material modification of an EEBOP may be implemented by a casino licensee or applicant until it has been approved by the Commission. Any request to revise an EEBOP shall be submitted at least 60 days in advance of the requested effective date of the change and shall include, without limitation, the following:

1. A clear and concise summary of any revisions, deletions or additions; and

2. A detailed explanation of the changes being proposed and their anticipated effect on the compliance of the casino licensee or applicant with the requirements of the Act and this chapter, which explanation shall include supporting data or documentation when available.

19:53-6.8 Annual EEBOP assessment hearing; statistical demonstration of compliance with obligations; demonstration of compliance through documentation of EEBOP implementation

(a) Each casino licensee or applicant shall be required to demonstrate its compliance with the requirements of the Act and this chapter through an annual assessment of its performance under its approved EEBOP.

(b) The annual EEBOP assessment of a casino licensee shall be scheduled either as part of its casino license renewal hearing or on the anniversary date of the license renewal, if the casino licensee is operating under a two year casino license.

(c) The annual EEBOP assessment of a casino license applicant shall occur on a schedule to be set by the Commission, which schedule shall be based on the anticipated date of either the initial licensure hearing of the applicant or, if a casino hotel is being built or renovated, the opening of the casino.

(d) Four months prior to the scheduled date of the casino license hearing or the annual EEBOP assessment hearing, the casino licensee or applicant shall submit the annual statistical report required pursuant to N.J.A.C. 19:53-4.6 and, in the case of a casino licensee, N.J.A.C. 19:53-5.8. The Commission shall review these reports and the report prepared pursuant to N.J.A.C. 19:53-2.10 and shall advise the casino licensee or appliant of its findings within 30 days.

(e) If the Commission finds, based on these reports, that the casino licensee or applicant has satisfied all of the performance goals set forth in N.J.A.C. 19:53-2.3, 4.4 and, if applicable, 5.3, the casino licensee or applicant shall be entitled to a determination that it has complied with the equal opportunity and affirmative action obligations imposed by the Act and this chapter and, except as otherwise provided in (g) below, no further annual EEBOP assessment proceedings shall be required.

(f) If the Commission finds that the casino licensee or applicant has failed to reach some or all of the performance goals set forth in N.J.A.C. 19:53-2.3, 4.4 and, if applicable, 5.3, the casino licensee or applicant shall be required to establish its good faith efforts to achieve such goals. The good faith of the casino licensee or applicant shall be demonstrated by its documentation, to the satisfaction of the Commission, of its implementation and compliance with those portions of its approved EEBOP which relate to the achievement of the performance goals as to which the casino licensee or applicant was deficient.

(g) Notwithstanding any other provision of this section, the Commission may direct any casino licensee or applicant to document its implementation and compliance with any programmatic portion of its approved EEBOP during the annual assessment period if such review is considered necessary to the achievement of the purposes of the Act and this chapter.

(h) Any documentation required by (f) or (g) above shall be submitted to the Commission and Division at least two months prior to the scheduled date of the annual EEBOP assessment hearing and shall include, as applicable and without limitation, the following:

1. An internal review and evaluation of each of the areas of the EEBOP which relate to the performance goals which were not achieved, including documentation of specific transactions or programs which were included in the EEBOP as a means to attain these goals;

2. An analysis by the casino licensee or applicant as to why the particular performance goals were not achieved, addressing such issues as the availability of workers or vendors, the performance of workers or vendors, or any other information which the casino licensee or applicant considers relevant to its failure to attain the particular performance goals;

3. An internal review and evaluation of each programmatic portion of its approved EEBOP as to which the Commission has directed an annual assessment pursuant to (g) above; and

4. Modifications to the approved EEBOP proposed by the casino licensee or applicant as a means to improve its performance in deficient areas during the next EEBOP assessment period.

(i) Upon completion of an annual EEBOP assessment hearing for a casino licensee or applicant which has failed to achieve some or all of the participation goals set forth in N.J.A.C. 19:53-2.3, 4.4 and, if applicable, 5.3, the Commission may find that the casino licensee or applicant has in fact exerted good faith efforts to comply with the obligations of the Act and this chapter if:

1. The casino licensee or applicant did implement and comply with the terms of its approved EEBOP during the assessment period; or

2. The failure of the casino licensee or applicant to comply with its approved EEBOP and, as a consequence, to achieve its performance goals was based on occurrences which were beyond the control of the casino licensee or applicant.

(j) If, upon completion of an annual EEBOP assessment hearing, the Commission determines that a casino licensee or applicant has failed to comply with the requirements of the Act, this chapter or its approved EEBOP, the Commission may impose one or more of the sanctions authorized by N.J.A.C. 19:53-6.11.

19:53-6.9 Special EEBOP reviews and hearings

(a) Notwithstanding any other provision of this chapter, the Commission may require a casino licensee or applicant to conduct a self assessment of all or any part of its approved EEBOP whenever the Commission has cause to question whether the EEBOP or the implementation of the EEBOP by the casino licensee or applicant is likely to achieve compliance with the obligations imposed by the Act and this chapter.

(b) Any casino licensee or applicant which is notified that a special review of its EEBOP shall be conducted pursuant to this section shall supply whatever documentation or reports are requested by the Commission. A special hearing on the EEBOP of the casino

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licensee or applicant may be ordered by the Commission at any time and shall be conducted under such terms and conditions as the Commission may direct. The sole purpose of such hearing shall be to determine whether the casino licensee or applicant should be required to make immediate modifications to its EEBOP consistent with the purposes of the Act and this chapter.

19:53-6.10 On-site monitoring and inspections

A representative of the Commission and a representative of the Division shall be entitled to enter the casino hotel, casino, casino simulcasting facility or any related facilities of a casino licensee or applicant for the purposes of determining whether the licensee or applicant is complying with the Act, this chapter and its approved EEBOP. In making such a determination, the Commission or Division shall be entitled to inspect or copy any relevant books or records.

19:53-6.11 Sanctions

(a) If the Commission determines that a casino licensee or applicant is in violation of any applicable provision of the Act, this chapter or its approved EEBOP, the Commission, as appropriate, may:

1. Impose penalties in accordance with N.J.S.A. 5:12-129;
2. Deny, suspend or revoke or refuse to renew the casino license;
3. Enter a cease and desist order which specifies the practice or contract to be discounted or altered by the casino licensee or applicant;
4. Issue public letters of reprimand or censure to be made a permanent part of the file of the casino licensee or applicant;
5. Assess appropriate civil penalties as allowed by the Act;
6. Refer to the Attorney General or his or her designee circumstances which may constitute violation of the "Law Against Discrimination," N.J.S.A. 10:5-1 et seq.;
7. Enforce in a court of law the applicable provisions of the Act, or join in or assist any enforcement proceeding initiated by an aggrieved person;
8. Impose license conditions; and
9. Take any other action authorized or permitted by the Act.

19:53-6.12 Waiver of reporting requirements for casino licensees

(a) If the contractor and subcontractor work force of a casino licensee meets all of the employment goals for women or minorities set forth in N.J.A.C. 19:53-2.3 for four consecutive quarters, the monthly reports required by N.J.A.C. 19:53-2.4(a)1 and 2 shall be waived.

(b) If the operations work force of a casino licensee meets all or any of the employment goals for women or minorities set forth in N.J.A.C. 19:53-4.4 for four consecutive quarters, the quarterly report required by N.J.A.C. 19:53-4.5 shall be waived as to any EEOC job categories for which compliance has been attained.

(c) If a casino licensee meets the applicable goals specified in N.J.A.C. 19:53-5.3 for goods and services purchased from certified and provisionally certified MBEs and WBEs for four consecutive quarters, the quarterly disbursement report required by N.J.A.C. 19:53-5.7 shall be waived.

(d) A waiver of the obligation to file certain reports as provided in this section shall not alter the obligation of a casino licensee to prepare and maintain such information and records on-site. In addition, the Commission reserves the right to seek and obtain from a casino licensee at any time any information that may be pertinent to determining the compliance of the casino licensee with the Act, this chapter and its approved EEBOP.

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# EMERGENCY ADOPTION

## TRANSPORTATION

## (a)

### DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
### BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
### Weight Limits
### Route U.S. 9 in Middlesex County
### Adopted Emergency New Rule and Concurrent Proposed New Rule: N.J.A.C. 16:30-6.1

Emergency New Rule Adopted and Concurrent Proposed New Rule Authorized: July 23, 1993 by Thomas M. Downs, Commissioner, Department of Transportation.

Gubernatorial Approval (see N.J.S.A. 52:14B-4(c)): July 27, 1993.

Emergency New Rule Filed: July 29, 1993 as R.1993 d.417.

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-75.

Concurrent Proposal Number: PRN 1993-466.

Emergency New Rule Effective Date: July 29, 1993.

Emergency New Rule Expiration Date: September 27, 1993.

Submit written comments by September 15, 1993 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625
(609) 530-2041

This new rule was adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of this emergency new rule are being proposed for readoption in compliance with the normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted new rule becomes effective upon the acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed prior to the emergency expiration date.

The agency emergency adoption and concurrent proposal follows:

**Summary**

The proposed new rule will establish a "weight limit" for trucks over four tons registered gross weight along the right hand lanes of Route U.S. 9 over the Raritan River, specifically on the Edison Bridge in the Borough of Sayreville and the Township of Woodbridge, Middlesex County, to protect the public safety. A recent Departmental bridge inspection of structure No. 1209-155, located along Route U.S. 9 over the Raritan River in Middlesex County, identified a critical structural crack in the steel superstructure below the right hand lane in the southbound direction. In response to the finding of this crack, a team of engineers from the Department's Bureau of Structural Evaluation and a consultant conducted field investigations which revealed that due to the critical nature of this crack and the possible occurrence of other cracks at similar locations throughout the structure, heavy trucks over four tons crossing this structure should be restricted from using the right hand lane in both directions. Continued heavy truck loads on this portion of the bridge could cause fatigue problems and/or cracks in some of the critical structural members.

In view of the demands created by the existing structural references and the need for trucks to use the bridge, the weight limit regulations for this portion of Route U.S. 9 are being amended.

**Social Impact**

The proposed new rule will establish a weight limit restriction and designated lane use along Route U.S. 9 at the Edison bridge in Sayreville Borough and Woodbridge Township for trucks over four tons registered gross weight to preserve the structure of the Edison bridge over the Raritan River and to enhance the safety and well-being of the populace. Appropriate signs will be erected to advise the motoring public.

**Economic Impact**

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of the "weight limit" signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rule will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

**Regulatory Flexibility Statement**

The proposed new rule does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed new rule primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

**Full text** of the emergency adopted and concurrently proposed new rule follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

16:30-6.1 [(Reserved)] **Route U.S. 9**

**For the protection and use of the Edison Bridge along Route U.S. 9 over the Raritan River in Sayreville Borough and the Township of Woodbridge, Middlesex County, there is established a weight limit of four tons registered gross weight. The right hand lane in both directions (mileposts 131.8 and 132.75) shall have a four ton gross weight limit. Trucks over four tons shall be restricted to using the left lane only on the Edison Bridge.**

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# PUBLIC NOTICES

## ENVIRONMENTAL PROTECTION AND ENERGY

## (a)

### ENVIRONMENTAL REGULATION

### Notice of Availability of Technical Manuals

**Take notice** that, pursuant to N.J.S.A. 13:1D-111, the Department of Environmental Protection and Energy (Department) has developed technical manuals which are now available to permittees, prospective applicants and the public. The Department has developed manuals for each class or category of permits as required under N.J.S.A. 13:1D-101 and 105. Each manual defines the procedural and substantive requirements for the completion of an application for a class or category of permit and the review thereof, and clarifies departmental policies and interpretations of any laws or regulations relating to the filing and review of an application.

Each manual also provides a detailed summary and explanation of policy considerations not otherwise identified by law, rule or regulation that are used in the Department's review and consideration of a permit application. Each manual also details and clarifies the Department's interpretation of standards or other requirements that do not have a fixed meaning or are not identified by law or regulation including, but not limited to, identification or stipulation of state-of-the-art control technologies and best management practices. Finally, each manual includes general information about departmental policies to facilitate the preparation by an applicant, and the review by the Department, of an application.

The following technical manuals are available:

**A. Air Quality Regulation Manuals**

No. 1001 Introduction for All Air Permit Applications (This manual may be obtained only with the purchase of any Technical Manual from Level 1 through 5, below.)

No. 1002 Guidance on Preparing an Air Quality Modeling Protocol

No. 1003 Guidance on Preparing a Risk Assessment Protocol for Air Contaminant Emissions

Level 1. Bureau of New Source Review

No. 1101 Air Permit Applications

Level 2. Bureau of New Source Review

No. 1201 Liquid Storage Tanks Greater than 40,000 Gallons, Emitting Less than 25 Tons/Year/Contaminant

No. 1202 Commercial Fuel Burning Equipment, Rated at Greater than 10 Million BTU/Hour, Less than 100 Million BTU/Hour Emitting Less than 25 Ton/Year/Contaminant

No. 1203 Air Stripping, Using Carbon Adsorption, or Thermal or Catalytic Oxidation or Control VOC Emissions

No. 1204 Soil Venting, Using Carbon Adsorption or Thermal or Catalytic Oxidation or Control VOC Emissions

No. 1205 Applications Submitted Under Non-Reactive Permitting Procedure with Emissions Less than 25 Tons/Year

No. 1206 Grinder Processing Hospital Waste

No. 1207 Clean Wood Waste Furnace Rated at Less Than 10 Million BTU/Hour

No. 1208 Asphalt Plant

No. 1209 Surface Coating Operation with Emissions of Less than 25 Tons/Year

No. 1210 Other Source Operations, Not Included in Another Level, Emitting Less than 25 Tons/Year/Contaminant

Level 3. Bureau of New Source Review

No. 1301 Batch Plant Production Permitting Procedure

No. 1302 Pilot Plant or Dual Plant Permitting Procedure

No. 1303 Cogeneration and Power Generation Using Gas or Oil, 10 Million BTU/Hour or Less

No. 1304 Wastewater and Sewage Sludge Treatment Operation

No. 1305 Solid Waste Applications Other than Solid Waste Combustion

No. 1306 Hospital Waste Processing, Using Autoclaves, Microwaves and Technologies Other Than Grinding

No. 1307 Flares

Level 4. Bureau of Air Quality Engineering

No. 1401 Groundwater and Leachate Storage and/or Treatment Tank

No. 1402 Landfill Gas Venting System

No. 1403 Groundwater and/or Leachate Treatment Plant

No. 1404 Low Temperature Volatilization Systems that Process Contaminated Soil and Sludge

No. 1405 Cogeneration and Other Power Generation Greater Than 10 Million BTU/Hour

No. 1406 Sludge Incinerators

No. 1407 Incinerators

No. 1408 Coal and Solid Fuel Fired Boilers

No. 1409 Reciprocating Engines

No. 1410 (1) Liquid and Gaseous Fuel Combustion for Energy Equipment Having Heat Input Greater Than 100 Million BTU/Hour and (2) All Boilers Having Heat Input Greater Than 100 Million BTU/Hour

Level 5. Office of Chief Engineers

No. 1501 Commercial Facilities That Treat Offsite-Generated Waste

No. 1502 Waste Oil Process By-Products or Other Non-Commercial Fuel Combustion

No. 1503 Hazardous Waste Incinerators and Associated Equipment

No. 1504 Site Clean-up with Hazardous Waste Incinerators or Treatment Equipment

No. 1505 Site Clean-up with Innovative Technology

**B. Hazardous Waste Regulation Program Manuals**

Hazardous Waste Facility (Part B) Permit or Permit Modifications

Generator Accumulation Tank Approval

Treatability Study Approval

Permit Exemption for On-Site Recycling to Produce Fuel

Hazardous Waste Facility Closure Plan Approval

**C. Land Use Regulation Program Manuals**

Stream Encroachment Permits

Freshwater Wetlands Permits

Coastal Zone Management Permits, includes CAFRA, Waterfront Development and Tidelands Management

**D. Wastewater Facilities Regulation Manuals**

**Bureau of Operational Groundwater**
Sanitary Unit/NJPDES/DGW

**Bureau of Operational Groundwater**
Industrial Unit/NJPDES/DGW

**Bureau of Pretreatment and Residuals**
NJPDES Permit

**Bureau of Pretreatment and Residuals**
NJPDES/SIU/Permit

**Bureau of Construction and Connections**
Treatment Works Approval (TWA)

**Bureau of Standard Permitting**
**Bureau of Watershed Permitting**
Treatment Works Approval for Industrial Indirect Discharges

**Bureau of Standard Permitting**
**Bureau of Watershed Permitting**
Treatment Works Approval for Industrial DSW/DGW Dischargers

**Bureau of Standard Permitting**
**Bureau of Watershed Permitting**
Discharge to Surface Water Permits
Discharge Allocation Certificates

**E. Division of Solid Waste Management Manuals**

**Bureau of Landfill Engineering Landfill Permits**

Includes new permits, major modifications, minor modifications, closure plans, permit renewals, transfer of ownership, minor technical reviews, annual topographic surveys, disruptions, Preliminary

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Environmental Health and Impact Statement, cover material requests, on-site disposal requests, ID-27 soil requests, miscellaneous technical reviews, methane venting systems.

**Bureau of Resource Recovery Incinerator Permits**

Includes new incinerator and thermal destruction units, small scale incinerators, permit renewals, continuation of expiring permits and transfers of ownership, major modifications, minor and miscellaneous technical reviews, Preliminary Environmental Health and Impact Statement, vegetative waste composting facilities.

**Bureau of Small Facility Review Material Recovery Facility and Transfer Station Approvals**

Includes transfer stations materials recovery facilities, new permits capacity expansion of existing facilities, major modifications, minor modifications, permit renewals, transfers of ownership, minor technical reviews, temporary certifications of authority to operate.

**Bureau of Small Facility Review Class B Recycling Center Approvals**

Includes modifications, renewals, transfers of ownership.

F. **Pesticide Control Program Manual**

**Bureau of Pesticide Operations**
Pesticide Control
Permits/Regulations/Licenses

G. **Water Supply Element Manuals**

**Bureau of Safe Drinking Water Public Water Works Facilities Approvals**

Includes new public water systems, new wells, new surface sources, treatment modifications, distribution modifications.

**Bureau of Water Allocation Water Allocation Permits**

Includes temporary dewatering permits, water use registrations, short term water use reports.

H. **Site Remediation Program Manual**

**Bureau of Aquifer Restoration**
NJPDES/DGW Permit

Any person who wishes to purchase any technical manuals may telephone (609) 777-1039 or write to the following address:

Map Sales and Publications Office
Bureau of Revenue
CN 417
Trenton, New Jersey 08625-0417

The Department will update these manuals periodically, but not more frequently than every six months except as required by law. Suggestions for improving a technical manual may be directed to Geoffrey Cromarty, Office of Permit Information and Assistance, NJDEPE, CN 423, Trenton, New Jersey 08625-0423. If the publication date of a manual is more than six months old or if the user of the manual is aware of a regulatory change, the user should contact the Maps and Publications Office for a copy of the appropriate revision.

## (a)

## GREEN ACRES PROGRAM

### Notice of Public Hearing

### Proposed Sewer Easement on Lands Located Within D & R Canal State Park

**Take notice** that the State of New Jersey, Department of Environmental Protection and Energy, will hold a **public hearing** to seek comments on the proposed easement on the following State-owned land:

Lands located within the D & R Canal State Park (Block 59, Lot 2) as shown on the current tax map of the Township of Frenchtown, Hunterdon County.

This land was acquired with 1978 Green Acres Bond Funds.

The applicant seeks this easement for the installation of a residential sewer line to enable connection with a municipal sewer system. Soil characteristics are not favorable for an environmentally acceptable septic system at this site.

The public hearing will be held on:

Monday, September 20, 1993 at 11:00 A.M. at the
Frenchtown Borough Hall located at Second Street
Frenchtown, New Jersey

Persons wishing to make oral presentation are asked to limit their comments to a five minute time period. Presenters should bring a copy of their comments to the hearing for use by the Department. The hearing record will be kept open for a period of seven days following the date of the public hearing so that additional written comments can be received.

**Interested persons** may submit written comments until September 27, 1993, to:

Thomas Wells, Administrator
Green Acres Program
Department of Environmental Protection and Energy
CN 412
Trenton, New Jersey 08625

## (b)

## OFFICE OF LAND AND WATER PLANNING

### Amendment to the Northeast Water Quality Management Plan

### Public Notice

**Take notice** that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Northeast Water Quality Management (WQM) Plan. This amendment proposal was submitted by the Bernards Township Sewerage Authority (BTSA). This proposal would update the BTSA Wastewater Management Plan by expanding the sewer service area in Bernards Township served by the Harrison Brook Sewage Treatment Plant. The service area will be expanded to address several lots with frontage upon roads wherein the center line of the road currently establishes the sewer service area boundary. The lots affected by this proposal include: Block 1—Lot 9, Block 5—Lot 1, Block 23—Lots 1, 2, 3, 5.01, 6, 7 and 8, Block 133—Lots 4, 5, 6, 7, 8, 9.01, 9.02, 10, 11, 12, 13, 14, 15, 16, 17 and 18, Block 172—Lots 35, 39, 39.01, 40, 41, and 42, and Block 175—Lots 19, 37.01, 38.01, 39.01, 40.01 and 45. The service area will be extended for these lots to include at least 200 feet measured from the center of the road. For some lots, the service area will extend greater than 200 feet from the road to include existing dwellings. In order to address the requirement of providing a future service area boundary based on recognizable geographic or political features (N.J.A.C. 7:15-5.20(b)), the BTSA amended their Rates, Rules and Regulations to include the proposed service area subject to approval of this amendment by the NJDEPE.

**This notice** is being given to inform the public that a plan amendment has been proposed for the Northeast WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN 423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

**Interested persons** may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Ms. Helene Fall, Bernards Township Sewerage Authority, Collyer Lane, Basking Ridge, N.J. 07920. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

**Any interested persons** may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

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## (a)

## OFFICE OF LAND AND WATER PLANNING

### Amendment to the Northeast and Upper Raritan Water Quality Management Plans

### Public Notice

**Take notice** that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Northeast and Upper Raritan Water Quality Management (WQM) Plans. This amendment proposal was submitted on behalf of New Providence Borough. The amendment provides a Wastewater Management Plan (WMP) for New Providence Borough. The WMP identifies the sewer service areas to the New Providence Sewage Treatment Plant (STP), the Joint Meeting of Essex and Union Counties (JMEUC) STP, and the Berkeley Heights STP. By agreement, the New Providence STP is currently permitted to pump up to 1.5 million gallons per day (mgd) of wastewater to the JMEUC STP. The WMP proposes an increase in the maximum allowable flow to be pumped to the JMEUC STP from 1.5 mgd to 3.0 mgd to allow for treatment of all dry weather and some wet weather flows generated within the New Providence plant's service area. This proposal would amend the JMEUC WMP. The New Providence STP discharges to the Passaic River and the JMEUC STP discharges to the Arthur Kill. This proposal would allow for an increase in the interbasin transfer of wastewater. In addition, a water quality study will be required to determine effluent limits for the flows above 3.0 mgd discharged from the New Providence STP.

**This notice** is being given to inform the public that a plan amendment has been proposed for the Northeast and Upper Raritan WQM Plans. All information related to the WQM Plans and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN 423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

**Interested persons** may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. Leo J. Coakley, Killam Associates, 27 Bleeker Street, Millburn, NJ 07041-1008. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

**Any interested persons** may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

## (b)

## OFFICE OF LAND AND WATER PLANNING

### Amendment to the Lower Raritan/Middlesex County Water Quality Management Plan

### Public Notice

**Take notice** that on July 9, 1993, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq. and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Lower Raritan/Middlesex County Water Quality Management Plan was adopted by the Department. This amendment redefines the sewer service area boundary between Stony Brook Regional Sewerage Authority and Middlesex County Utilities Authority and increases current and future population and flow projections. This amends the South Brunswick Township Wastewater Management Plan.

## (c)

## OFFICE OF LAND AND WATER PLANNING

### Amendment to the Monmouth County Water Quality Management Plan

### Public Notice

**Take notice** that on July 9, 1993, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Monmouth County Water Quality Management Plan was adopted by the Department. This amendment allows the Millstone Township Board of Education to abandon the existing on-site wastewater disposal system at the Millstone Elementary School and construct a new on-site wastewater disposal system to serve a new elementary school and the existing elementary school which will be converted to a middle school.

## (d)

## OFFICE OF LAND AND WATER PLANNING

### Amendment to the Upper Delaware Water Quality Management Plan

### Public Notice

**Take notice** that on July 9, 1993, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Upper Delaware Water Quality Management Plan was adopted by the Department. This amendment, requested by representatives of Blair Plaza, Inc., removes Lots 1, 2, 3-01, 3-02 and 3 in Block 703 of Blairstown Township from the sewer service area of the proposed Lambert Road Sewage Treatment Plant. These lots are designated for service by On-site Ground Water Disposal Facilities. Of the five lots, three of these (Lots 1, 2 and 3-01) have already been developed with on-site ground water disposal facilities. The property owned by Blair Plaza, Inc. (Lots 3 and 3-02) is the only property left to be developed. The lots are located between Route 94 and Buchanan Road (County Route 674) in the Highway Commercial Zone.

## (e)

## OFFICE OF LAND AND WATER PLANNING

### Amendment to the Tri-County Water Quality Management Plan

### Public Notice

**Take notice** that on July 14, 1993, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Tri-County Water Quality Management Plan was adopted by the Department. This amendment transfers designation of the Affordable Living Development (Block 307, Lot 3) and the Moriuchi tract (Block 307, Lot 4) located west of Borton Landing Road and north of Westfield Road from sewer service area 2 (the proposed Creek Road Sewage Treatment Plant) to sewer service area 1 (the existing Pine Street Sewage Treatment Plant). The amendment also updates erroneous information contained within the adopted Moorestown Wastewater Management Plan. In addition, a small parcel of land below Salem Road and above Borton Landing Road that was not intended for sewer service was removed from sewer service area 2 (Block 7400, Lot 2).

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# HEALTH

## (a)

### CERTIFICATE OF NEED REVIEW SERVICES

### Notice of Certificate of Need Call Schedule

**Take notice** that, in accordance with the provisions of N.J.A.C. 8:33-4.1(a), Bruce Siegel, M.D., M.P.H., Commissioner, New Jersey Department of Health, is providing notice of the anticipated certificate of need schedule for the period July 1993 through January 1994.

| | |
|---|---|
| 10/1/93 | Hospital Capital Batch<br>Bed Categories:<br>Medical/Surgical<br>Obstetrics<br>Acute Psychiatric<br>IC/CCU<br>Cardiac Catheterization Expansion<br>Surgical Services<br>Acute Renal Services<br>Upgrade of major moveable equipment<br>MICU services for the southern part of Warren County (to complete the statewide advanced life support system) |
| 11/1/93 | Comprehensive rehabilitation beds |
| 12/1/93 | Maternal and Child Health Consortia |
| 1/1/94 | Long-term Care Ventilator Beds |

Please note that additional or special calls for Certificate of Need applications beyond those identified may be announced and calls identified in this notice may not be announced.

## (b)

### DIVISION OF HEALTH FACILITIES EVALUATION AND LICENSING

### Notice of Receipt of Petition for Rulemaking Hospital Licensing Standards N.J.A.C. 8:43G-6.10(c)2

Petitioner: Steven J. Picco, Esq., representing New Jersey Health Care Payers Coalition.

**Take notice** that on June 30, 1993, the New Jersey State Department of Health received a petition from Steven J. Picco, representing the New Jersey Health Care Payers Coalition. The petition requests that the Department amend its hospital licensing standards regulations, N.J.A.C. 8:43G-6.10(c)2, to allow for public examination of records collected on deaths in anesthetizing locations or intraoperative or postoperative events or outcomes related to anesthesia. The specific amendment language suggested is "Records of such reports and telephone calls shall be made available to Department of Health personnel for official purposes and, for each report, to the specific facility to which the report pertains. This report shall be considered a public record for the purposes of N.J.S.A. 47:1A-1 et seq."

In accordance with the provisions of N.J.A.C. 1:30-3.6, the Department shall subsequently mail to the petitioners, and file with the Office of Administrative Law, a notice of action on the petition.

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# HUMAN SERVICES

## (a)

## DIVISION OF YOUTH AND FAMILY SERVICES

### Notice of Availability of Grant Funds Family Preservation Services

**Take notice** that in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the Department of Human Services announces the following availability of funds:

**Name of Grant Program:** Family Preservation Services.

**Purpose for which the grant program funds shall be used:** This program is intended to provide technical assistance to new and/or existing Family Preservation Services programs. Assistance to programs would include, but not be limited to: compliance with the Homebuilder's program model from Washington State; compliance with DHS/DYFS contract policies and procedures; monitoring and maintaining program levels of service; monitoring referral activity; keeping accurate records to demonstrate the capability for effective fiscal and program management.

**Amount of money in the grant program:** Contingent upon receipt of federal funds, the Division of Youth and Family Services (DYFS) will make available total statewide funding in the amount of $180,000 in Title IV-A, Emergency Assistance Funds for this program. There is no match requirement. Funds awarded to selected applicants shall be continuous upon renegotiations of future contracts, if providers demonstrate positive technical assistance outcome and compliance with DYFS contract requirements. Total funding shall not exceed an annualized amount of $180,000, to be distributed to assist four regional and one central catchment areas of the State, as follows:

- Northern Region—$35,000
- Metropolitan Region—$35,000
- Central Region—$35,000
- Southern Region—$35,000
- Statewide representative located in the DYFS Central Office—$40,000

**Organizations that may be eligible to apply for funding under this program:** One or several community social service agencies in the State, including those agencies that currently administer a Family Preservation Services program funded by DYFS and/or that demonstrate capability in providing technical assistance to new and/or existing Family Preservation Services programs, are eligible for selection. All submitted proposals that are complete and fulfill the requirements of the Request For Proposals (RFPs) will be eligible for selection.

**Qualifications needed by an applicant to be considered for funding:** In all cases, applicants must demonstrate compliance with the following provisions:

(1) The applicant must demonstrate a comprehensive understanding of the purpose and intent of the Homebuilder's/Family Preservation Services initiative's philosophy and treatment mode;

(2) The applicant must be willing to enter into a contract with DYFS and willing to comply with DYFS policies and with the contracting rules and regulations of the Department of Human Services;

(3) The applicant must be willing to adhere specifically to the technical assistance requirements contained in the RFP and comply with DYFS monitoring and evaluation procedures;

(4) The applicant must not discriminate in providing services to program staff based on age, race, creed, national origin, sex, handicap or financial status; and

(5) The applicant must be willing to adhere specifically to reporting requirements, as specified in the RFP.

**Application selection criteria:** Applications for funds shall be evaluated and scored in accordance with the criteria listed below.

The maximum score for all proposals shall equal 100 points and shall be computed based on the following:

- Demonstration by the applicant of a comprehensive understanding of the purpose and intent of the Homebuilder's/Family Preservation Services initiative's philosophy and treatment mode (maximum of 25 points);
- The applicant's overall capability to provide technical assistance to one or more FPS providers simultaneously or upon request (maximum of 10 points);
- Applicant's ability to demonstrate clarity and originality in the proposal and to describe attainability of technical assistance, provide an implementation plan and to state intention to demonstrate assurance of compliance with contract requirements (maximum of 25 points);
- Demonstration of the applicant's current or proposed working relationship with DYFS and FPS providers or their proposed plan for developing such a relationship (maximum of 15 points);
- Reasonableness of applicant's proposed budget plan (maximum of 10 points);
- Applicant's receptiveness to DYFS's monitoring and evaluation of technical assistance implementation (maximum of 15 points).

**Procedures for eligible applicants to apply:** Agencies and individuals interested in applying for these funds may obtain a copy of the Request for Proposals from the Division of Youth and Family Services, CN 717, Trenton, New Jersey 08625 or by calling Alisha Griffin at (609) 292-0590. A Bidders' Conference is scheduled for:

Date: Tuesday, August 24, 1993
Time: 1:00 P.M.
Location: Forrestal Center, 600 College Road, Princeton, New Jersey

Agencies and individuals interested in applying for funds may also obtain a copy of the Request for Proposals by attending the Bidders' Conference.

**Address to which applications must be submitted:** Agencies and individuals interested in applying for these funds should submit one signed original and 10 copies of the Request for Proposals and all required attachments comprising the proposal application package to the Division of Youth and Family Services by 5:00 P.M. on Wednesday, September 15, 1993.

**Proposals may be hand-delivered to:**
Division of Youth and Family Services
Office of Statewide Operations and Support
Capital Center
50 East State Street—7th Floor
Trenton, New Jersey 08625
Attention: Alisha Griffin, Assistant Administrator

**Proposals may be mailed to:**
Division of Youth and Family Services
Office of Statewide Operations and Support
CN 717
Trenton, New Jersey 08625
Attention: Alisha Griffin

**Deadline by which applications must be submitted:** The completed application and all supporting materials and copies must be received by 5:00 P.M. on Wednesday, September 15, 1993, at the Division of Youth and Family Services. Applications may be mailed or hand-delivered. No late applications will be considered for funding, regardless of postmark.

**Date by which applicants shall be notified of acceptance:** October 7, 1993.

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## (b)

## DIVISION OF THE DEAF AND HARD OF HEARING

### Notice of Availability of Grant Funds Telecommunications Device for the Deaf Distribution Program

**Take notice** that in compliance with N.J.S.A. 52:14B-34.4, 34.5 and 34.6, the Division of the Deaf and Hard of Hearing announces the availability of free telecommunications devices for the deaf (TDDs) to eligible citizens.

**A. Name of program:** TDD Distribution Program.

**B. Purpose:** To create access to services provided by private and public agencies and businesses.

**C. Amount of available funding for the program:** A total of $52,000 for one year, the State fiscal year 1993.

**D. Organizations which may apply for a TDD:** None.

**E. Qualifications needed by an applicant to acquire a free TDD:** If single annual income of $16,171 or if married $19,828 excluding real property; a degree of hearing loss or speech impairment which precludes the use of the standard voice telephone; New Jersey Resident, one per household.

There is a limited supply available and they will be distributed to qualified applicants in the order received on a regional basis.

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**F. For additional information please contact:**
Division of the Deaf and Hard of Hearing
CN 074
Trenton, New Jersey 08625-0074
(609) 984-7281 V/TDD or (800) 792-8339 V/TDD

## (a)

## NEW JERSEY COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

### Notice of Availability of Grant Funds Project Foresight

**Take notice** that in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the New Jersey Commission for the Blind and Visually Impaired hereby announces the availability of the following grant program funds.

**A. Name of program:** Project Foresight.

**B. Purpose:** To develop a Statewide initiative to ensure a comprehensive approach to vision and hearing health among preschool children who are in child care settings, including expansion of age appropriate vision and hearing screening, intervention and followup, through a partnership of child care providers, parents, health professionals, community organizations and government agencies utilizing a two phase approach. Phase I lasting six months is the planning stage; while Phase II lasting approximately 2½ years is the implementation stage. Target population is the birth to five year old age group.

**C. Amount of available funding for the program:** A total of $250,000 is available for one year. Three contracts will be awarded in order to serve each region of the State (Southern, Central, Northern) averaging $83,000 each. These contracts may be renewable for up to three years upon performance and availability of funds.

**D. Organizations which may apply for this funding:** Public agencies and profit or not-for-profit private agencies, organizations, associations, including, but not limited to, child care agencies, colleges, health professionals, or community groups.

Linkages between entities are encouraged. Joint or cooperative proposals are acceptable.

**E. Qualifications needed by an applicant to be considered for funding:** Ability to provide both Phase I (planning) and Phase II (implementation); Knowledge of and/or experience with hearing screening and/or vision screening, and/or child care system; Knowledge of region and services in area of application; Ability to access child care community within area of application; Ability to conduct a demographic needs analysis, develop a regional advisory group, provide public relations including conducting conferences, as needed, and act as an advocate for the target population; Capability of coordinating and/or providing screenings for the target population; Ability to initiate and assist in followup to screenings; Ability to work closely and cooperatively with the New Jersey Commission for the Blind and Visually Impaired; Commission for the Blind and Visually Impaired; Ability to maintain accurate and up-to-date records and to report results of program and fiscal expenditures on a regularly scheduled basis; Ability to access minority populations, including those that are non-English speaking.

**F. Procedure for eligible organizations to apply:** RFP will be available as of August 18, 1993 from the address indicated below or by telephone. **A Technical Assistance Workshop** will be held during the week of August 30, 1993. Information about this Workshop will be available at the address and telephone number below.

**G. Address to which applications must be submitted:**
Program Development/Contract Unit
New Jersey Commission for the Blind and Visually Impaired
153 Halsey Street, PO Box 47017
Newark, NJ 07101
(201) 648-4799 or (201) 648-2899

**H. Deadline by which applications must be submitted:** October 7, 1993.

**I. Date applicant is to be notified of acceptance or rejection:** November 5, 1993.

## (b)

## CHILD LIFE PROTECTION COMMISSION

### Notice of Grant Fund Availability Children's Trust Fund

**Take notice** that in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the Child Life Protection Commission (CLPC) hereby announces the availability of the following grant program funds for the Children's Trust Fund's fiscal year July 1, 1994 to June 30, 1995:

**Name of program:** Children's Trust Fund.

**Purpose:** The Children's Trust Fund is a private/public foundation, established by the New Jersey Legislature to provide funds for programs designed to prevent child abuse and neglect. The fund is administered by the Child Life Protection Commission, which is appointed by the Governor. The Children's Trust Fund is staffed by and located in, but not of, the Department of Human Services. Contracts with grantees are awarded by the New Jersey Department of Human Services.

**Amount of money in the program:** The amount of money available for 1994-95 is dependent upon the total amount of monies derived from direct contributions, a State income tax check-off and a Federal Community-based Child Abuse and Neglect Prevention Grant. In 1993, $603,549 was disbursed to 38 grantees. The average grant was $20,139.

**Organizations which may apply for funding under this program:** Public agencies and private non-profit agencies with 501(c)(3) federal tax determination letters may apply to develop community-based child abuse and neglect prevention programs. Documentation of 501(c)(3) status is required in the Full Grant Application for private agencies.

**Funding:** Funding for all grantees is annual, with eligibility for funding consideration for three consecutive years. Second and third year funding follows a step-down policy, with local match requirements.

**Qualifications needed by an applicant to be considered for funding:** A recipient of a grant from the Children's Trust Fund shall use the grant funds only to fund primary or secondary child abuse and child neglect prevention programs. Grants from the Children's Trust Fund may not be used to meet the non-federal matching requirements of Federal law. Priority is given to grant proposals that target populations at high risk of child abuse and neglect. Applicants are encouraged to consider successful prevention strategies when designing a Children's Trust Fund grant application: **Note:** Tertiary prevention programs serving adults who have abused or neglected children are ineligible for funding.

**Please note the Procedure for eligible organizations to apply:** There is a different procedure with different forms for (A) first year funding applicants and for (B) continuation applicants.

**A. First Year Funding Applications**

First year funding applicants must complete a Preliminary Grant Application. These may be obtained by calling the Children's Trust Fund, (609) 633-3992, Monday through Friday from 9:00 A.M. to 5:00 P.M., or by writing to the Children's Trust Fund at CN 711, Trenton, NJ 08625. Preliminary Grant Applications will be available for distribution commencing August 16, 1993. Completed Preliminary Applications must be submitted by October 8, 1993. **In order to be eligible for a first year grant, an applicant must complete and submit a Preliminary Grant Application.** On or about December 1, 1993, the Child Life Protection Commission will invite selected applicants to submit a Full Grant Application on a form supplied by the CLPC, which will be due on January 31, 1994.

**B. Continuation Applications**

Current first and second year grantees must complete a Continuation Grant Application to be eligible for further funding consideration. The Child Life Protection Commission will mail these applications directly to current first and second year grantees on or about December 7, 1993. Grantees who wish to apply for continuation funding must submit the Continuation Grant Application by January 31, 1994.

**Address to which and deadline by which applications must be submitted:**

Preliminary Grant Applications must be postmarked on or before October 8, 1993 to:
Children's Trust Fund
CN 711
Trenton, New Jersey 08625
or hand-delivered before 5:00 P.M. on October 8, 1993 to:

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Children's Trust Fund Office
N.J. Department of Human Services
222 South Warren Street
5th Floor
Trenton, New Jersey 08625

No facsimile will be accepted.

Full Grant Applications may be submitted by invitation only, after approval of the Preliminary Grant Application, and must be postmarked or hand-delivered on or before January 31, 1994.

Continuation Grant Applications must be postmarked or hand-delivered on or before January 31, 1994.

**Date by which notices shall be mailed of approval of disapproval of applications:**

Preliminary Grant Applicants—December 1, 1993
Full Grant Applicants—April 15, 1994
Continuation Grant Applicants—April 15, 1994

Questions may be directed to the Children's Trust Fund, (609) 633-3992.

## (a)

## DIVISION OF FAMILY DEVELOPMENT

### Revised Notice of Availability of Grant Funds Title of Grant: Family Development Program

**Take notice** that, in compliance with N.J.S.A. 52:14-34.4, 34.5, and 34.6, the Department of Human Services, acting under the authority of Public Law 1991, Chapter 523, hereby announces the availability of the following grant program funds. This revised notice extends the grant monies for the General Assistance Family Development Program for employable recipients to additional municipalities in Essex and Hudson Counties as noted below. This notice amends the notice published in the August 2, 1993 Register at 25 N.J.R. 3564(a).

**A. Name of program:** General Assistance Family Development Program.

**B. Purpose:** To establish a work/training program that offers intensified and coordinated services to address the educational, vocational and other employment-related needs of those employable clients served by the General Assistance program in the county of Camden in the City of Camden; in the county of Essex in the municipalities of Newark, East Orange, Irvington, Montclair, and Orange; and in the county of Hudson in the municipalities of Bayonne and Jersey City.

**C. Amount of available funding for the program:** $3,551,000 funding will be provided for the reasonable costs associated with the administration of the program and for core program services.

**D. Organizations which may apply for funding under this program:** Public or private-for-profit or not-for-profit agencies that can provide trained personnel to accomplish the various service components of the General Assistance Family Development Program in municipalities in the counties of Camden, Essex and Hudson with General Assistance employable caseloads of 150 or more cases. Agency proposals must serve the employable GA population in the designated municipalities in the aforementioned counties or any portion of the geographic area(s) specified above. The service components of the program include but are not limited to:

1. Case management.
2. Individual client/family assessments.
3. Job development.
4. Co-location of program components.
5. Employability plans.
6. Referral services:
   Training;
   Educational programs;
   Community work experience;
   Job search;
   Social or rehabilitative services, as appropriate;
   Other employment-oriented activities.
7. Linkages with other community programs to secure and coordinate resources in the community.

**E. Procedure for eligible organizations to apply:** Request for Proposal (RFP) packages were made available on **August 2, 1993**. Interested applicants may request an **RFP**, in writing, from:

Department of Human Services
Division of Family Development
Office of the Director
CN 716
Trenton, New Jersey 08625
Or, by telephone: (609) 588-2401

Additional information and technical assistance will be provided to interested applicants at a **Bidders Conference** to be held at the Division of Family Development, Quakerbridge Plaza, Building #9, Third Floor, Conference Room, Trenton, New Jersey, on August 9, 1993 at 10:00 A.M.

Request for Proposal packages will be available, upon request, at the Bidders Conference.

**F. Address to which applications must be submitted:** Applicants should submit one signed original and seven copies of the completed Request for Proposal document and all support materials to:

Department of Human Services
Division of Family Development
Office of the Director
CN 716
Trenton, New Jersey 08625

**G. Deadline by which applications must be submitted:** The completed RFP document and all required supporting material must be received by the Office of the Director, at the above address, by **4:00 P.M. on Wednesday, September 15, 1993.**

**H. Date the applicant is to be notified of acceptance or rejection:** September 27, 1993.

# INSURANCE

## (b)

## DIVISION OF THE NEW JERSEY REAL ESTATE COMMISSION

### Notice of Receipt and Action on Petitions for Rulemaking

Petitioner: New Jersey Land Surveyor's Council.

Authority: N.J.S.A. 45:15-6.

**Take notice** that on April 23, 1993 the New Jersey Real Estate Commission (Commission) received 11 petitions for rulemaking from the New Jersey Land Surveyor's Council ("Petitioner").

The petitions request that the Commission act upon a series of proposed rules regarding land surveys and the use by licensees of surveys and of substitutes for new surveys. The subjects of the proposed rules are as follows:

1. An administrative rule to prohibit purchase, promotion or use of any "wash-out survey" on any basis;
2. An administrative rule requiring the Commission to acknowledge receipt of all correspondence and to notify any and all effected parties within five working days following action by the Commission on any matter;
3. An administrative rule prohibiting the use of any land or boundary survey over 90 days old for the purposes of conveyancing or mortgaging real properties;
4. An administrative rule to define the necessity for a land or boundary survey in every real property conveyance and/or financial transaction in which real property is to be used as collateral for a loan or mortgage;
5. An administrative rule to define the fiduciary duty of a licensee when ordering or advising a client about ordering a land or boundary survey;
6. An administrative rule providing treble damages for licensees who do not take good care when purchasing, soliciting for, receiving or using any land or boundary survey which fails to meet the "minimum technical standards;"
7. An administrative rule to limit the removal of the survey exception in "Schedule 'B'" to cases where the land or boundary survey of the subject real property is current;
8. An administrative rule to prohibit the use of any land or boundary survey without an accompanying map, plat, drawing or sketch which meets the requirements of the "minimum technical standards;"

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9. An administrative rule prohibiting illegal "deed plot surveys" used for the purpose of circumventing the requirement for a full boundary survey;

10. An administrative rule to define land or boundary surveys; and

11. An administrative rule prohibiting the use of an "owners survey affidavit and indemnification agreement" in lieu of a correct survey.

The petitioner identified itself as an unincorporated organization of persons either registered as land surveyors in New Jersey or who have any interest in land surveying. The petitioner also stated that the professional activities of many of its members are regulated, in part, by the Commission, and that the interests of its members will be damaged if the rules as petitioned are not implemented.

Initially, the Commission notes that it does not directly regulate land surveyors (which are licensed and regulated by the State Board of Professional Engineers and Land Surveyors, **see** N.J.S.A. 45:8-27 et seq.) or title insurance. The Commission acknowledges that it regulates the involvement of licensed brokers and salespersons in real estate conveyance and financing transactions, N.J.S.A. 45:15-1 et seq. Some of the rules requested by the petitioner may directly affect the Commission's regulation of real estate licensees, such as the proposals suggested in paragraphs 5 and 6 above. On the face of the petitions, however, it appears that several of the proposed rules more directly impact the regulatory jurisdiction of the State Board of Professional Engineers and Land Surveyors, the Department of Banking (with respect to the mortgaging of real property), or the Department of Insurance (with respect to the conduct of its licensees' participation in the issuance of title insurance). The Department notes that the petitions did not specifically reference the Commission's statutory authority to take the requested action on each of the petitions, as required by N.J.A.C. 11:1-15.2(a)4.

Pursuant to N.J.A.C. 11:1-15.3, upon due consideration of the petitions in accordance with law, the Commission's action on all 11 petitions shall be to refer them for further deliberations to be concluded on or before December 1, 1993. Because the 11 separate petitions for rules appear to be interrelated and to provide a comprehensive regulatory scheme on related subject matter, it is appropriate that none of the petitions be denied at this time, pending further examination by the Commission on their effect upon those proposed rules that directly affect the business of real estate brokerage and the conduct of real estate licenses. The further deliberations shall address the following regarding the petitions for proposed rules:

1. To examine the statutory authority of the Commission to adopt rules as requested in the petitions, consistent with its responsibilities to regulate the business of real estate brokerage.

2. To gather more information regarding the nature of the problems presented and proposed to be addressed by the rules, that is, whether the problems asserted by the petitioner are problems that affect the public generally, or whether they are limited to a particular constituency, and how the problems relate to the business of real estate brokerage as presently conducted in this State;

3. To gather more information about how these problems are addressed, if at all, by other State agencies that appear also to have jurisdiction over some or all of the subject matter, particularly: the State Board of Professional Engineers and Land Surveyors; the Department of Banking; and the Department of Insurance; and

4. To recommend whether the petitions, or any of them, should be proposed as rules by the Commission regarding the business of real estate brokerage.

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# LAW AND PUBLIC SAFETY

## (a)

### DIVISION OF CONSUMER AFFAIRS
### STATE BOARD OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS

### Notice of Action on Petitions for Rulemaking
### N.J.A.C. 13:40

Petitioner: T.S. Madson II, Executive Director, New Jersey Land Surveyor's Council.

**Take notice** that on April 22, 1993, the State Board of Professional Engineers and Land Surveyors received 18 petitions for rulemaking from T.S. Madson II, Executive Director of the New Jersey Land Surveyor's Counsel ("petitioner") asserting that Board licensees are engaging in acts which are a clear and present danger to the health, welfare, safety and property of the people of New Jersey. See 25 N.J.R. 3032(a).

**Take further notice** that the Board reviewed these petitions at its May 21st and June 3rd meetings and determined that additional time was needed to study and evaluate petitioner's positions. Accordingly, the Board voted to refer the petitions to a subcommittee for further analysis. The Board anticipates that it will conclude its deliberations and respond to the petitioner on or before September 16, 1993.

A copy of this notice has been mailed to the petitioner, as required by N.J.A.C. 1:30-3.6.

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# REGISTER INDEX OF RULE PROPOSALS AND ADOPTIONS

## The research supplement to the New Jersey Administrative Code

# A CUMULATIVE LISTING OF CURRENT PROPOSALS AND ADOPTIONS

The **Register Index of Rule Proposals and Adoptions** is a complete listing of all active rule proposals (with the exception of rule changes proposed in this Register) and all new rules and amendments promulgated since the most recent update to the Administrative Code. Rule proposals in this issue will be entered in the Index of the next issue of the Register. **Adoptions promulgated in this Register have already been noted in the Index by the addition of the Document Number and Adoption Notice N.J.R. Citation next to the appropriate proposal listing.**

Generally, the key to locating a particular rule change is to find, under the appropriate Administrative Code Title, the N.J.A.C. citation of the rule you are researching. If you do not know the exact citation, scan the column of rule descriptions for the subject of your research. To be sure that you have found all of the changes, either proposed or adopted, to a given rule, scan the citations above and below that rule to find any related entries.

**At the bottom of the index listing for each Administrative Code Title is the Transmittal number and date of the latest looseleaf update to that Title. Updates are issued monthly and include the previous month's adoptions, which are subsequently deleted from the Index. To be certain that you have a copy of all recent promulgations not yet issued in a Code update, retain each Register beginning with the July 6, 1993 issue.**

**If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers.** A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

**Terms and abbreviations used in this Index:**

**N.J.A.C. Citation.** The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

**Proposal Notice (N.J.R. Citation).** The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

**Document Number.** The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of promulgation of the rule and its chronological ranking in the Registry. As an example, R.1993 d.1 means the first rule filed for 1993.

**Adoption Notice (N.J.R. Citation).** The New Jersey Register page number and item identification for the publication notice and text of an adopted amendment or new rule.

**Transmittal.** A series number and supplement date certifying the currency of rules found in each Title of the New Jersey Administrative Code: Rule adoptions published in the Register after the Transmittal date indicated do not yet appear in the loose-leaf volumes of the Code.

**N.J.R. Citation Locator.** An issue-by-issue listing of first and last pages of the previous 12 months of Registers. Use the locator to find the issue of publication of a rule proposal or adoption.

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**MOST RECENT UPDATE TO THE ADMINISTRATIVE CODE: SUPPLEMENT JUNE 21, 1993**

**NEXT UPDATE: SUPPLEMENT JULY 19, 1993**

**Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.**

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# N.J.R. CITATION LOCATOR

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| 24 N.J.R. 2753 and 2970 | August 17, 1992 |
| 24 N.J.R. 2971 and 3202 | September 8, 1992 |
| 24 N.J.R. 3203 and 3454 | September 21, 1992 |
| 24 N.J.R. 3455 and 3578 | October 5, 1992 |
| 24 N.J.R. 3579 and 3784 | October 19, 1992 |
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| 2:6 | Animal health: extension of comment period regarding biological products for diagnostic or therapeutic purposes | 24 N.J.R. 3981(a) | | |
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**Most recent update to Title 12: TRANSMITTAL 1993-5 (supplement June 21, 1993)**

**COMMERCE AND ECONOMIC DEVELOPMENT—TITLE 12A**

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| 12A:1 | Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA) | 25 N.J.R. 1335(b) | | |
| 12A:9 | Development of small businesses and women and minority businesses: waiver of sunset provision of Executive Order No. 66(1978) | 25 N.J.R. 1335(c) | | |
| 12A:9 | Development of small businesses and women and minority businesses | 25 N.J.R. 1752(a) | R.1993 d.309 | 25 N.J.R. 2689(a) |
| 12A:11-1.2, 1.3, 1.4, 1.7 | Certification of women-owned and minority-owned businesses: extension of comment period | 25 N.J.R. 2216(c) | | |
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| 12A:120 | Urban Enterprise Zone Program and business certification | 25 N.J.R. 2645(b) | R.1993 d.416 | 25 N.J.R. 3837(a) |

**Most recent update to Title 12A: TRANSMITTAL 1993-3 (supplement June 21, 1993)**

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| 13:1C | Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA) | 25 N.J.R. 1338(a) | | |
| 13:19-1.1, 1.7 | Driver Control Service: administrative hearings applicability | 25 N.J.R. 893(a) | R.1993 d.389 | 25 N.J.R. 3503(a) |
| 13:19-10.1 | Operating motorcycle or motorized bicycle without protective helmet | 25 N.J.R. 2646(a) | | |
| 13:20-37 | Motor vehicles with modified chassis height | 24 N.J.R. 3662(a) | | |
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| 13:20-38 | Dimensional standards for automobile transporters | 25 N.J.R. 1342(a) | R.1993 d.380 | 25 N.J.R. 3504(a) |
| 13:20-43 | Enhanced motor vehicle inspection and maintenance program: pre-proposal | 25 N.J.R. 3418(a) | | |
| 13:26 | Transportation of bulk commodities | 25 N.J.R. 1343(a) | | |
| 13:29-1.13 | Board of Accountancy: biennial renewal fee for inactive or retired licensees | 25 N.J.R. 1665(b) | | |
| 13:30-1.1 | Board of Dentistry: qualifications of applicants for licensure to practice | 25 N.J.R. 2216(d) | | |
| 13:30-8.5 | Board of Dentistry: complaint review procedures | 24 N.J.R. 2800(a) | | |
| 13:30-8.6 | Board of Dentistry: professional advertising | 24 N.J.R. 2801(a) | R.1993 d.332 | 25 N.J.R. 2898(a) |

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| 13:33-1.35, 1.36 | Ophthalmic dispensers and technicians: referrals; space rental agreements | 24 N.JR. 4010(a) | | |
| 13:34 | Board of Marriage Counselor Examiners rules | 25 N.J.R. 3060(a) | | |
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| 13:35-10 | Practice of athletic trainers | 25 N.J.R. 265(a) | | |
| 13:35-11 | Board of Medical Examiners: Alternative Resolution Program | 25 N.J.R. 2824(b) | | |
| 13:37 | Board of Nursing rules | 25 N.J.R. 455(b) | | |
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| 13:37-12.1, 14 | Board of Nursing: certification of homemaker-home health aides | 25 N.J.R. 1950(a) | | |
| 13:38-1.2, 1.3, 2.5 | Practice of optometry: permissible advertising | 24 N.J.R. 4237(a) | R.1993 d.357 | 25 N.J.R. 3232(a) |
| 13:39-1.3 | Board of Pharmacy: fee schedule | 25 N.J.R. 1666(a) | R.1993 d.414 | 25 N.J.R. 3839(a) |
| 13:39-5.2 | Board of Pharmacy: information on prescription labels | 25 N.J.R. 1667(a) | | |
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| 13:42 | Board of Psychological Examiners rules | 25 N.J.R. 3062(a) | | |
| 13:43 | State Board of Shorthand Reporting rules | 25 N.J.R. 3079(a) | | |
| 13:44C | Audio and Speech-Language Pathology Advisory Committee rules | 25 N.J.R. 1668(a) | R.1993 d.383 | 25 N.J.R. 3504(b) |
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| 13:45A-24 | Toy and bicycle safety | 24 N.J.R. 3019(b) | R.1993 d.372 | 25 N.J.R. 3235(a) |
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| 13:70-14A.1 | Thoroughbred racing: intent of medication rules | 25 N.J.R. 3099(a) | | |
| 13:70-14A.9 | Thoroughbred racing: administering medication to respiratory bleeders | 25 N.J.R. 3100(a) | | |
| 13:70-20.11 | Thoroughbred racing: limitations on entering or starting | 25 N.J.R. 3101(a) | | |
| 13:70-21.4 | Thoroughbred racing: medication | 25 N.J.R. 3102(a) | | |
| 13:70-29.50 | Thoroughbred racing: daily triple payoff in dead heat for win | 25 N.J.R. 1671(a) | R.1993 d.366 | 25 N.J.R. 3238(a) |
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| 13:71-2.3 | Harness racing: suspension from driving | 25 N.J.R. 2647(b) | | |
| 13:71-5.18 | Harness racing: minimum age for admittance to racetrack | 25 N.J.R. 2648(a) | | |
| 13:71-23.1 | Harness racing: intent of medication rules | 25 N.J.R. 3104(a) | | |
| 13:71-23.3B, 23.3C | Harness racing: pre-race blood gas analyzing machine testing program | 25 N.J.R. 3427(a) | | |
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| 13:71-27.50 | Harness racing: trifecta | 25 N.J.R. 3106(a) | | |

**Most recent update to Title 13: TRANSMITTAL 1993-6 (supplement June 21, 1993)**

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| 14:18-2.11 | Cable television: pre-proposal regarding disposition of on-premises wiring | 24 N.J.R. 4496(a) | | |
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**Most recent update to Title 14: TRANSMITTAL 1993-3 (supplement June 21, 1993)**

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**Most recent update to Title 14A: TRANSMITTAL 1993-1 (supplement February 16, 1993)**

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| **STATE—TITLE 15** | | | | |
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| 16:28-1.41 | Speed limit zones along U.S. 9 in Berkeley Township and Pine Beach Borough | 25 N.J.R. 1834(a) | R.1993 d.327 | 25 N.J.R. 2913(c) |
| 16:28-1.48, 1.93 | Speed rates along Route 167 in Port Republic and Route 44 in Greenwich and West Deptford | 25 N.J.R. 2225(a) | R.1993 d.400 | 25 N.J.R. 3841(a) |
| 16:28-1.92 | Speed limit zones along Route 169 in Bayonne and Jersey City | 25 N.J.R. 2834(a) | | |
| 16:28-1.125 | Speed limits along Route 67 in Fort Lee | 25 N.J.R. 3442(a) | | |
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| 16:28A-1.20, 1.25, 1.31, 1.41 | Restricted parking and stopping along Route 29 in Lambertville, Route 35 in Berkeley Township, Route 45 in Woodbury, and Route 77 in Bridgeton | 25 N.J.R. 3127(a) | | |
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| 16:84 | NJ TRANSIT: disability discrimination complaint procedure | 25 N.J.R. 3445(b) | | |
| 16:85 | NJ TRANSIT: contracting policies and procedures | 25 N.J.R. 3450(a) | | |

**Most recent update to Title 16: TRANSMITTAL 1993-6 (supplement June 21, 1993)**

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| 17:1-10, 11 | State Prescription Drug Program; Dental Expenses Program (recodify to 17:9-8, 9) | 25 N.J.R. 675(b) | R.1993 d.268 | 25 N.J.R. 3506(b) |
| 17:9 | State Health Benefits Program | 25 N.J.R. 2651(b) | | |
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| 18:7-1.16 | Corporation Business Tax: financial businesses | 25 N.J.R. 1841(a) | R.1993 d.364 | 25 N.J.R. 3239(a) |
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| 18:35 | Gross Income Tax; setoff of individual liability | 25 N.J.R. 1500(a) | R.1993 d.315 | 25 N.J.R. 2906(b) |
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| 19:9-2.7 | Turnpike Authority construction contracts: withdrawal of bid for unilateral mistake | 25 N.J.R. 62(b) | R.1993 d.326 | 25 N.J.R. 2906(d) |
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**Most recent update to Title 19: TRANSMITTAL 1993-6 (supplement June 21, 1993)**

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| 19:40-2.5 | Delegation of Commission authority | 24 N.J.R. 2348(a) | R.1993 d.409 | 25 N.J.R. 3737(b) |
| 19:40-5.2 | Practice of law before Commission | 25 N.J.R. 1672(a) | R.1993 d.316 | 25 N.J.R. 2907(b) |
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| 19:43-4.1 | Casino bankroll | 25 N.J.R. 1672(b) | R.1993 d.317 | 25 N.J.R. 2907(c) |
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| 19:46-1.1, 1.4, 1.5 | Gaming chips | 25 N.J.R. 3111(a) | | |
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