

Test Alert!

American School of Business
New Jersey Life and Health Law
Supplement

5/31/06

L&H

The information included in this release, in addition to your other Kaplan Financial materials, is designed to assist you in preparing for concepts that your exam may include. We urge you to read it carefully and take time to review the sample questions and rationales.

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On page 2, insert the following content after the section entitled “Certificate of Authority”:

Principal Office

The principal office of an insurer is generally the office from which the insurer directs or manages its affairs. With respect to alien insurers who are authorized to transact insurance in one or more US states, it is the office in the United States from which the insurer directs or manages its affairs.

[Secs. 17B:17-10, 12]

On page 2, insert the following content after the section entitled “Insurance Agent”:

The insurance code defines the solicitation of insurance as the attempt to sell insurance to a person from a particular insurer. The sale of insurance is the exchange of an insurance contract or policy on behalf of an insurer for any valuable consideration. The negotiation of insurance involves any act that provides a buyer or prospective buyer of insurance with information about the benefits, terms, or conditions of a policy if the party giving the information sells or obtains insurance for buyers.

On page 5, replace the first two paragraphs under the section entitled “The Commissioner” with the following content:

Department of Banking and Insurance

The Department of Banking and Insurance regulates the banking and insurance industries in New Jersey. The chief executive officer of the Department is the Commissioner, who is appointed by the governor for the duration of the governor’s term in office and until a successor is appointed and approved. The Commissioner has the power to make and enforce rules and regulations that implement New Jersey’s insurance laws.

[Secs. 17:1-8.1, 17:1-15, 16; 17:22A-20]

The Commissioner has a number of important duties, most of which are delegated to the department’s various divisions for actual performance. The Commissioner may appoint deputy commissioners to act in his stead when necessary.

[Sec. 17:1-14]

On page 5, insert the following content before the last paragraph under the section entitled “The Commissioner”:

The Department of Banking and Insurance has two divisions: the Division of Banking and the Division of Insurance. Each division has its own director. Each director reports directly to the Commissioner.

On page 12, add the following content after the first paragraph:

New Jersey Insurance Fraud Prevention Act

The New Jersey Insurance Fraud Prevention Act is intended to address insurance fraud in the state by securing the means to detect it, eliminating it through fraud prevention programs, requiring restitution of insurance benefits obtained through fraud, and reducing the amount of premium dollars used to pay fraudulent claims.

[17:33A-2]

The state attorney general and the director of the Division of Anti-Fraud Compliance in the Department of Banking and Insurance share enforcement authority.

Violations of the act. A person or entity violates the act by doing any of the following:

- Knowingly making a false or misleading statement concerning a material fact or information on a claim for payment or benefit under an insurance policy or the Unsatisfied Claim and Judgment Fund Law
- Knowingly concealing or failing to disclose a fact that affects a person's right or entitlement to an insurance benefit or payment or the amount of a benefit or payment
- Preparing a written or oral statement intended to be given to an insurer or producer for the purpose of obtaining an insurance policy, knowing that the statement contains false or misleading information about a material fact concerning the insurance application or policy
- Knowingly concealing or failing to disclose evidence that may be relevant in showing that a material fact about an application or policy for insurance was knowingly concealed or misrepresented, or that such material fact was not knowingly concealed or misrepresented
- Knowingly assisting, conspiring with, or encouraging anyone to violate the act
- Knowingly benefiting from the proceeds resulting from a violation of the act
- Knowingly benefiting from the proceeds that result from the assistance, conspiracy, or encouragement of any person in violating the act

[17:33A-4]

Penalties for violations. If the Commissioner finds that a person has violated the act, he may:

- bring a civil suit against the offender; or
- assess a civil penalty and order the offender to pay restitution to the victim of the fraud.

A fine may be assessed against the offender as follows:

- \$5,000 for the first offense
- \$10,000 for the second offense
- \$15,000 for subsequent offenses

The Commissioner may, in addition to or as an alternative to these penalties, ask the attorney general to charge the offender with a criminal offense. Furthermore, the Commissioner may refer the matter to the state licensing authorities, who may suspend or revoke the offender's license.

[17:33A-5]

Surcharge. In addition to any penalty, fine, or charge, a person who is found to have committed insurance fraud is subject to a surcharge of \$1,000. If the person charged settles the case with a money payment, he is subject to a surcharge equal to 5% of the settlement payment. This money is paid to the state treasurer. The Department of Banking and Insurance uses the money to fund its efforts to fight insurance fraud.

[17:33A-5.1]

Actions by insurance companies. An insurance company that is a victim of insurance fraud may sue to recover money it spent on investigating the claim, filing the lawsuit, and attorneys' fees. If the defendant is found to be liable and to have engaged in a pattern of insurance fraud, the insurance company is entitled to three times that amount of money. The Commissioner may join in the insurance company's suit and recover civil penalties from the defendant.

An insurance company cannot sue a party for insurance fraud more than six years after it knew or should have known that it was a victim of insurance fraud.

[17:33A-7]

Reporting and investigating suspicions of fraud. Anyone who believes that insurance fraud is being, or will be, committed must notify the Division of Anti-Fraud Compliance. The division will examine the facts of the alleged violation to determine whether fraud, deceit, or intentional misrepresentation exists.

No one is liable for libel, violation of privacy, or otherwise simply for filing a report or giving information related to good-faith suspicions of insurance fraud.

[17:33A-9]

Fraud prevention and detection plan. Every insurance company writing health insurance in New Jersey must file with the Commissioner a plan for prevention and detection of fraudulent insurance applications and claims. The Commissioner will either approve or reject the plan within 90 days of filing. If the Commissioner fails to act within this period, the plan will be deemed to have been approved. The Commissioner may impose a penalty of up to \$25,000 per violation on any insurer who fails to submit, implement, or report on this plan.

[17:33A-15]

On page 17, replace the second paragraph with the following content:

If a license lapsed less than one year before an application for renewal, the applicant can apply for late renewal by attaching the following items to the application:

- Proof that the applicant met all continuing education requirements to date
- Certification that the applicant has or has not transacted any insurance business as a producer during the unlicensed period and, if it has, information about the number of policies transacted
- The late renewal fee

[Sec. 11:17-2.5]

On page 17, replace the last paragraph with the following content:

Education and Examination Exemption

In general, resident applicants for insurance licenses in New Jersey must pass a state licensing examination administered by the Department of Banking and Insurance or a vendor under contract with the Department.

Exemptions. Applicants for certain limited lines of insurance (ticket insurance, group mortgage cancellation insurance, legal insurance, credit insurance, and self-storage personal property insurance) do not need to pass a state licensing exam. Persons with certain professional designations are also exempt from the exam requirements. For life and health insurance, persons holding a Chartered Life Underwriter (CLU) or a Chartered Financial Consultant (ChFC) designation are exempt. Applicants who were previously licensed as nonresidents and apply for licensure as residents are also exempt.

Order to retake exam. The Commissioner may, for good cause, order a licensee to retake the state examination within a specified period of time. If the licensee fails to retake the exam within this period, the Commissioner will order the licensee to show why the license should not be revoked and offer a hearing on the matter. Similarly, the Commissioner may refuse to issue a license to a license applicant and order the applicant to retake the exam within a specified period. If the applicant fails to do so, the Commissioner may refuse to issue the license and advise the applicant of his right to a hearing on the matter.

On page 32, insert the following content before the section entitled “Fines”:

Discharge of Insurer’s Liability

If an insurer pays the proceeds of a life or health insurance policy or makes a final payment under an annuity contract, the insurer is discharged of all claims on the policy or contract.

[Sec. 17B:24-5]

Proceeds Exempt from Creditors’ Claims

If proceeds are paid to a beneficiary of a life insurance policy (other than to the insured himself or paid with the intent to defraud creditors), they are exempt from creditors’ claims. Similarly, proceeds paid under an annuity contract are

protected from creditors if they total less than \$500 per month for installment payment period. Creditors may garnish payments that exceed this monthly limit. Furthermore, if the payments due to an annuitant exceed \$500 per month, a court may order the annuitant to pay a creditor the portion of the excess benefits that are reasonable in light of the debtor's financial circumstances.

[Secs. 17B:24-6, 7, 8]

If proceeds are paid under a health insurance policy or an accidental death and dismemberment policy, they are exempt from creditors' claims. However, creditors may sue to collect amounts due on contracts the insured entered into for necessities after the benefit period began.

Separate Premiums for Separate Risks

If a policy gives coverage for more than one hazard or peril, the insurance against a particular hazard or peril cannot be cancelled separately unless a separate premium is charged for that coverage. A life insurance policy or annuity contract cannot cover anything other than bodily injury or accidental death and the health of the insured.

[Sec. 17B:24-12]

On page 47, insert the following content before the section entitled "Life Insurance Solicitation Rules":

Violations of Laws Regarding Replacement

An agent or insurer violates the laws regarding replacement by:

- using deceptive or misleading information in sales material;
- failing to ask an applicant pertinent and required questions about the possibility of financing or replacement;
- knowingly recording an applicant's answer incorrectly;
- advising an applicant to respond negatively to a question regarding replacement to prevent giving notice to the existing insurer; or
- advising a policyholder to write directly to the insurance company in a way that attempts to obscure the identity of the replacing producer or insurer.

Penalties. A producer or insurer that violates the rules of replacement will be subject to revocation or suspension of a license or certificate of authority, monetary fines, and the forfeiture of any commissions or compensation paid to the producer for the transaction. If the Commissioner finds that the violation was material to the sale, the insurer or producer may be ordered to pay restitution to the insured, restore policy or contract values, and pay interest on the amounts paid back.

[Sec. 11:4-2.9]

On page 50, insert the following content before the section entitled “Advertising”:

Contracts with Minors

A minor who is at least 15 years old may enter into contracts for annuities or insurance, or affirm such contracts, on his own life and health or on the life and health of another person in whom the minor has an insurable interest.

Capacity to accept payment. A minor can accept an insurer’s payment (and discharge the insurer’s duty to pay it) under an annuity or insurance policy in which the minor has an insurable interest or is a beneficiary as follows.

- Minors who are at least 15 years old may accept payments of up to \$2,000 in a single calendar year.
- Minors who are at least 18 years old may accept payments of up to \$5,000 in a single calendar year.
- Payment may be made to the minor’s legal guardian, if one has been appointed.
- A minor cannot use his minority to break or void an insurance contract. A minor cannot be bound by an agreement to pay, by promissory note or otherwise, any premium on an annuity or insurance policy. (In such a case, the insurer may terminate coverage.)

[Sec. 17B:24-2]

On page 58, replace the paragraph entitled “Proofs of Loss” with the following content:

Proof of Loss. An insured is required to give written proof of loss to an insurer within 90 days after the date of a loss. With respect to policies that provide periodic payment contingent upon a continuing loss, the insured must give written proof of loss to the insurer within 90 days after the end of the period for which the insurer is liable. Failure to give this proof within the time required does not affect the claim if it was not reasonably possible for the insured to give proof within that time and the insured gives proof as soon as reasonably possible. Unless the insured is legally incapable of giving this proof (e.g., by reason of mental illness), the proof cannot be submitted more than one year after it is required.

[Sec. 17B:26-10]

On page 59, insert the following content before the section entitled “Optional Provisions”:

Additional Standards

Health insurers writing policies for individuals must offer the following coverages:

- 90 days of hospital room and board expenses
- Outpatient and ambulatory surgery
- Fees for operating room and special care unit

- Emergency room fees
- Physician's fees incurred with hospital care, outpatient, and ambulatory surgery
- Anesthesia, oxygen, radiation, and x-ray therapy
- Delivery room fees, medical expenses of newborns, and treatment for complications of pregnancy
- Intravenous solutions, blood, and plasma
- Inpatient physical therapy
- Outpatient physical therapy at 30 visits each year per covered person
- Dialysis
- Diagnostic tests and hospital laboratory fees
- Pharmaceuticals administered in a hospital
- Dressings and splints
- Treatment for biologically based mental illness
- Treatment for alcoholism and substance abuse
- Childhood immunizations
- Physician visits for illness or injury

[Sec. 17B:27A-4.5]

On page 61, insert the following content before the section entitled "Policy Definitions":

Health Insurance Reform Markets

Persons who are eligible to participate in a group health benefits plan that provides coverage for hospital or medical expenses must not be covered by an individual health benefits plan that provides the same or similar coverage provided in the group plan. An employer or producer who causes a person to be covered by an individual health benefits plan when that person is eligible to participate in a group health benefits plan, or who already participates in one, is subject to a fine. This fine will be at least twice the annual premium paid for the individual health plan, plus penalties.

[Secs. 17B:27A-1 to 16]

Coverage for domestic partners. An individual health insurance policy that offers dependent coverage must offer this coverage to the insured's domestic partner. A domestic partner is defined as a person, with the insured, is in a registered domestic partnership recognized by the state, shares a common address with the insured, lives in a domestic relationship with the insured, and who has expressed the intent to be in such a domestic relationship with the insured.

[Sec. 17B:27A-7.9]

Coverage for dependent children. A health insurance policy that covers hospital or medical expense benefits under which dependent coverage is available cannot deny coverage for a policyholder's child because the child:

- was born out of wedlock;
- is not claimed as a dependent on the policyholder's federal tax return; or
- does not live with the policy holder or in the insurer's service area, if the child complies with the terms and conditions of the policy with respect to using specified providers.

If a child is covered by the policy of a noncustodial parent, the insurer must:

- give information to the custodial parent as needed for the child to obtain benefits through the child's noncustodial parent's coverage;
- allow the custodial parent to submit claims for covered services without approval of the noncustodial parent; and
- pay claims directly to the custodial parent, the health care provider, or the Department of Human Services administering the state Medicaid program, as is appropriate.

If a parent who is the policy holder is eligible for dependent coverage and is under a court or administrative order to provide the child with health insurance coverage, the insurer must:

- allow the parent to enroll the child as a dependent, regardless of any enrollment season restrictions;
- allow the child's other parent, the Division of Medical Assistance and Health Services as the state Medicaid agency, or the Department of Human Services to enroll the child under the policy if the parent who is the policyholder fails to do so; and
- not terminate the child's coverage unless the parent who is the policy holder gives the insurer satisfactory written evidence that the court or administrative order is no longer in effect, or that the child is or will be enrolled in a comparable health benefits plan with coverage taking effect on the day that the existing coverage ends.

[Sec. 17B:27A-4.1]

Maternity coverage. Health insurance policies issued in New Jersey must provide the following benefits for maternity care provided to a mother and her newborn child in a licensed health care facility:

- At least 48 hours of inpatient care following a vaginal delivery
- At least 96 hours of inpatient care following a cesarean section

However, an insurer is not required to provide this minimal coverage for inpatient care unless the attending physician orders such care as medically necessary or the mother requests it.

[Sec. 17B:7.1]

Mastectomy coverage. Individual health insurance policies that provide hospital or medical expense coverage must cover inpatient care for at least 72 hours following a modified radical mastectomy and at least 48 hours of inpatient care after a simple mastectomy. If a patient, after consulting with the physician, decides that a shorter stay is sufficient, the insurer does not need to provide coverage for a longer stay.

[Sec. 17B:27A-7.2]

Renewal of coverage. An individual health insurance policy must guarantee coverage for an eligible person and his dependents on a community-rated basis.

Termination of coverage. While a health insurance policy is renewable with respect to an eligible person and his dependents at his option, an insurer may terminate coverage if the policyholder:

- fails to pay the premiums; or
- has acted fraudulently or made a material misrepresentation of material fact.

Nonrenewal of coverage. A health insurer may nonrenew a health insurance plan only if:

- the individual is no longer eligible for coverage because he is no longer a resident of the state or becomes eligible for a group health plan, government plan, or church plan;
- the insurer is allowed to cancel or amend the individual health benefits plan;
- the insurer is allowed to nonrenew that type of health benefits plan; or
- the insurer is allowed to withdraw from doing business in the individual health benefits market.

New Jersey Individual Health Coverage Program

All qualified insurers are required to participate in the state's Individual Health Coverage Program, which helps insurers offer individual health insurance to persons who might otherwise be unable to obtain coverage as standard risks. These insurers pay annual assessments to cover losses and administrative expenses borne by all members of the program. The assessments are based on the proportion of their respective market share. Insurers who pay claims in amounts that exceed a percentage of their income are entitled to reimbursement from the program.

[Secs. 17B:27A-10 to 16, et seq.]

On page 61, add the following content to the bottom of the page:

Preexisting Conditions

Health insurance policies cannot exclude coverage for a preexisting condition, though an exclusion may apply to a late enrollee or to any group of two to five persons if it does not exclude coverage for more than 180 days after the effective date of coverage and relates only to conditions appearing during the

six months immediately preceding the enrollment date. However, if 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition exclusion will apply to them.

[Secs. 17B:27A-22, 55]

On pages 62 and 63, replace the paragraph entitled “Exclusions” with the following content:

Prohibited exclusions. No health insurer may exclude coverage for any of the following as a preexisting condition:

- A newborn child who, as of the end of the 30 days following birth, is covered by creditable coverage
- A child who is adopted or placed for adoption before age 18 and who, as of the end of the 30 days following the date of adoption or placement for adoption, is covered by creditable coverage
- Pregnancy

[Secs. 17B:27A-22, 55]

Permitted exclusions. A health insurer may impose a preexisting condition exclusion in a group health plan if:

- the exclusion relates to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before the enrollment date of the member or beneficiary;
- the exclusion lasts for no more than 12 months, or 18 months for a late enrollee, after the enrollment date of the member or beneficiary; and
- the period of the preexisting condition exclusion is reduced by the total period of creditable coverage that the member or beneficiary has by the enrollment date.

[Secs. 17B:27A-22, 55]

On page 67, replace the paragraph entitled “Direct payment to health care providers” and the subsequent paragraphs up to “Policy Forms” on page 68 with the following content:

Payment to health care providers. Health insurance policies that indemnify for loss of life pay benefits to the insured’s beneficiaries. Benefits may also be paid directly to a hospital or medical services provider with the insured’s prior authorization. Such authorization does not require the consent of beneficiaries, if any.

[Sec. 17B:27-45]

Limitations on legal actions. As noted before, no one can sue to recover on a policy until at least 60 days have passed after proof of loss has been filed in accordance with the terms of the policy. Furthermore, no one can bring suit when three or more years have passed after proof of loss was required.

[Sec. 17B:27-46]

Required coverages. Group accident and health insurance policies sold or offered for sale in New Jersey are required to cover the following.

- **Reconstructive breast surgery.** A group health insurance policy must cover reconstructive breast surgery, corrective surgery, prostheses, and outpatient chemotherapy following surgery for cancer patients.
[Sec. 17B:27-46.1a]
- **Maternity benefits.** A group health insurance policy must cover maternity care without regard to marital status for expenses incurred in pregnancy and childbirth.
[Sec. 17B:27-46.1b]
- **Home treatment of hemophilia.** A group health insurance policy must cover medical expenses incurred in the treatment of bleeding associated with hemophilia.
[Sec. 17B:27-46.1c]
- **Treatment of Wilm's tumor.** A group health insurance policy must cover hospital or medical expenses incurred in the treatment of Wilm's tumor, including autologous bone marrow transplants when standard chemotherapy is unsuccessful.
[Sec. 17B:27-46.1e]
- **Mammograms.** A group health insurance policy is required to cover one baseline mammogram examination for women who are at least 35 but less than 40 years old; a mammogram every year for women who are at least 40 years old; and a mammogram as often as deemed medically necessary by a woman's health care provider if the woman is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors.
[Sec. 17B:27-46.1f]
- **Maternity care.** A group health insurance policy must provide benefits for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care after a cesarean section for a mother and newborn child in a licensed health care facility. Nevertheless, an insurer need not provide these hours of coverage unless the attending physician determines that this inpatient care is medically necessary or the mother requests it.
[Sec. 17B:27-46.1k]
- **Other coverages required.** Group health insurance plans must also cover lead poisoning screenings and child immunizations, treatment of diabetes, pap smears, diagnostic screenings, inpatient treatment of mastectomies, medical foods and low protein modified food products, audiology and speech pathology, anesthesiology and hospitalization for dental services, treatment of biologically based mental illness, hemophilia, infertility treatments, colorectal cancer treatment, and nonstandard infant formulas.
[Sec. 17B:27-46.1l, m-z]

Coordination of benefits provision. A group health insurance contract can use a coordination of benefits (COB) provision and may designate itself as the primary coverage. A group plan that uses a COB provision cannot take into account the benefits of another plan in determining its benefits. Group coverage that supplements basic benefits can stipulate that the supplementary coverage is in excess to any other parts of a plan provided by the same contract holder.

[Secs. 11:4-28.3, 5, 6]

Prohibited reduction of benefits. A group health insurance policy cannot reduce benefits for any of the following reasons:

- Another plan exists
- A person is or could have been covered by another plan, except with respect to Medicare Part B
- A person has chosen an option under another plan that provides a lower level of benefits than another option that could have been elected

Rules for coordinating benefits. The following is the order in which benefits are paid when the insured is covered by more than one policy.

1. The primary plan pays benefits as if the secondary plan did not exist.
2. A secondary plan takes the benefits of another plan into account only when it is secondary to that plan.
3. A plan that covers the person other than as a dependent will pay benefits before any other plan that covers the person as a dependent.

Rules for determining benefits for a dependent child when the parents are not separated or divorced. The following is the order in which benefits are paid for a dependent child when the parents are not separated or divorced.

1. The benefits of the plan of the parent whose birthday is earlier in the year will be determined before the plan of the parent whose birthday is later.
2. If both parents have the same birthday, the benefits of the plan that covered the parent longer will be determined before those of the plan that covered the parent for a shorter time.

Rules for determining benefits for a dependent child when the parents are separated or divorced. The following is the order in which benefits are paid for a dependent child when the parents are separated or divorced.

1. The plan of the parent who has custody of the child will have its benefits determined first.
2. The plan of the spouse of the parent with custody of the child will have its benefits determined next.
3. The plan of the noncustodial parent will have its benefits determined last.
4. If a court orders a parent to be responsible for the health care expenses of the child and if that parent's plan is secondary and has actual knowledge of the court order, its benefits will be determined first.

Other rules for determining benefits. The following rules apply for determining order of payment in other situations.

- Benefits of a plan that covers a person as an employee (who is not laid off or retired or a dependent of that person) are determined before those of a plan that covers the person as a laid-off or retired employee or dependent of that person.
- If a person has continuing coverage under federal or state law (i.e., through COBRA) and is also covered by another plan, the plan covering the person as an employee, retiree, or dependent of that person is primary. The continuation coverage is secondary.

Prompt payment of claims. A health insurer is obligated to pay a claim if the following conditions have been met:

- The claim is eligible for health care service from an eligible health care provider
- The claim has no material defect or deficiency (such as lacking proper documentation)
- The payor has no reason to believe that the claim is fraudulent
- The claim does not require special treatment that would prevent a timely payment

An insurer that delays payment even though these conditions have been met is liable to the claimant for the sum plus simple interest at 10% per year.
[Sec. 17B:26-9.1]

Timely payment of claims. In general, a health insurer must pay all legitimate claims under the following time frames:

- Within 30 calendar days of having received a claim filed electronically
- Within 40 days of having received a claim filed by nonelectronic means

Disputed claims. If a claim is disputed or denied because of missing information or documentation, the insurer must pay the claim within 30 or 40 calendar days of receiving the missing information or documentation.
[Sec. 11:22-1.5]

Record of payment. A health insurer is required to keep an auditable record of when payments were made to health care providers or insureds.

On page 83, add the following content to the end of the page:

Health Care Quality Act

All health maintenance organizations in New Jersey must meet the requirements to qualify for a certificate of authority as would any other insurer. They are to demonstrate financial soundness in the delivery of their health care services and the schedule of charges for these services.

[Sec. 26:2]-1, 4]

Basic Health Care Services

Basic health care services include emergency care, inpatient hospital and physician care, and outpatient medical services.

[Sec. 26:2]-2]

Health Care Services Required

HMOs must provide coverage for the following services:

- Treatment of Wilm's tumor
- Basic health care services
- Mammograms
- Prescription drugs and pharmacological services
- Preventive medical examinations and tests, including annual consultations with a health care provider to encourage healthy lifestyles and habits
- Cancer treatment
- Maternity care
- Treatment for diabetes
- Pap smears
- Prostate cancer tests
- Mastectomies, related surgeries for reconstruction, and prostheses
- Treatment of inherited metabolic diseases (including medical and modified foods)

[Secs. 26:2-4.1 to 17]

Discrimination Against Victims Of Domestic Violence Prohibited

An HMO cannot deny health care services for treatment of injuries sustained as a result of domestic violence. Health care services are to be provided to the same extent as for any other treatment.

[Sec. 26:2]-18]

Part II
New Sample Questions

There are no new questions at this time.

Part III

Answers and Rationales

There are no new answers or rationales at this time.

Part IV
Errata

There are no corrections at this time.

To submit comments or suggestions, please send an email to errata@kaplan.com.

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Reorder No.: 5310-9102
ISBN: 0-7931-9226-9