CHAPTER 21

SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17B:27A-17 et seq.; and P.L. 2005, c. 375.

Source and Effective Date

R.2004 d.107 and d.108, effective February 19, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a);
35 N.J.R. 4438(a), 36 N.J.R. 1605(a).

Chapter Expiration Date

Subchapter 3A and Appendix Exhibit BB, Part 6 expired on February 19, 2009.

In accordance with N.J.S.A. 52:14B-5.1c, Subchapters 1, 2, 3, 4, 6, 7, 7A, 8, 9, 10, 11, 13, 15, 16, 17, 18, 19, 20, 21 and 23, and Appendix Exhibits A, D, F, G, H, K, N, O, T, V, W, Y, BB Parts 1 through 5, CC, DD, FF, GG, HH, II and KK, expire on August 18, 2009. See: 41 N.J.R. 84(a), 41 N.J.R. 1147(a).

Chapter Historical Note

Chapter 21, Small Employer Health Benefits Program, was adopted as R.1993 d.553, effective October 15, 1993. See: 25 N.J.R. 3599(a), 25 N.J.R. 5253(a).

Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was adopted as R.1993 d.551, effective October 15, 1993. See: 25 N.J.R. 4572(a), 25 N.J.R. 5347(a).

Subchapter 15, Relief From Obligations Imposed Under the Small Employer Health Benefits Program, was adopted as R.1993 d.629, effective November 5, 1993. See: 25 N.J.R. 4577(a), 25 N.J.R. 5692(a).

Subchapter 6, Standard Employer and Employee Application and Small Employer Certification Forms, Subchapter 7, Program Compliance, Subchapter 17, Fair Meeting Standards, and Subchapter 18, Petitions for Rules, were adopted as R.1993 d.644, effective November 12, 1993. See: 25 N.J.R. 4437(a), 30 N.J.R. 5668(a).

Subchapter 3A, Non-Standard Health Benefits Plan, was adopted as R.1994 d.499, effective September 2, 1994. See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).

Subchapter 9, Informational Rate Filing Requirements Pursuant to the Small Employer Health Benefits Program, was adopted as R.1994 d.25, effective December 9, 1993. See: 25 N.J.R. 5757(a), 26 N.J.R. 245(a).

Subchapter 16, Withdrawals of Small Employer Carriers From the Small Employer Health Benefits Plans Market, was adopted as R.1994 d.26, effective December 9, 1993. See: 25 N.J.R. 4859(a), 26 N.J.R. 247(a).

Subchapter 2, New Jersey Small Employer Health Benefits Program Plan of Operation, was adopted as R.1994 d.48, effective December 22, 1993. See: 25 N.J.R. 4563, 26 N.J.R. 391(a).

Subchapter 8, Carrier Certification of Non-Member Status, and Subchapter 10, The Market Share Report, were adopted as R.1994 d.228, effective April 11, 1994. See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

Subchapter 11, Nonstandard Health Benefits Plan Filings With the Commissioner: Form Filings and Request to Withdraw Plan Forms, was adopted as R.1994 d.580, effective November 21, 1994. See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

Subchapter 11, Nonstandard Health Benefits Plan Filings With the Commissioner: Form Filings and Request to Withdraw Plan Forms, was renamed Nonstandard Health Benefits Plans (Filings With the Commissioner): Requirements for Maintaining Nonstandard Plans, and Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was repealed by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Subchapter 19, SEH Program Premium Comparison Survey, was adopted as R.1995 d.289, effective June 5, 1995. See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).

Subchapter 7A, Loss Ratio Reports; Dividends and Credits, was adopted as R.1996 d.213, effective May 6, 1996. See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).

Subchapter 3A, Non-Standard Health Benefits Plan, was repealed and Subchapter 3A, Non-Standard Health Benefits Plans, was adopted as new rules by R.1997 d.62, effective February 3, 1997. See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Subchapter 13, Nonstandard Plans: Withdrawal of Plans, was adopted as R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Pursuant to Executive Order No. 66(1978), Subchapters 1 through 7, 8, 10, 17, 18, and Appendix Exhibits A through KK of Chapter 21, Small Employer Health Benefits Program, were readopted by the Small Employer Health Benefits Program Board as R.1998 d.512, effective September 25, 1998 and Subchapters 7A, 9, 11, 13, 15, 16, 19 and Appendix were readopted by the Department of Banking and Insurance as R.1998 d.533, effective October 15, 1998. See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a); 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

Subchapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 17, 18, 23 and Appendix Exhibits H, N, O, T, CC, DD, and KK were readopted as R.2004 d.107, effective February 19, 2004. Subchapters 7A, 9, 11, 13, 15, 16, 19 and Appendix Exhibits BB, FF, and GG, were readopted as R.2004 d. 108, effective February 19, 2004. As part of R.2004, d.107, Subchapter 5, Standard Claim Form, was repealed effective March 15, 2004. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended (N.J.S.A. 17B:27A-17 et seq.), herein referred to as 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.

Petition for Rulemaking: Exhibit G.
See: 26 N.J.R. 2488(b), 26 N.J.R. 3089(a), 26 N.J.R. 3758(a).
Petition for Rulemaking: Exhibit G.
See: 26 N.J.R. 5120(a), 27 N.J.R. 1321(b).
Petition for Rulemaking: Exhibits A through G.
See: 26 N.J.R. 5120(c), 27 N.J.R. 946(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted additional P.L. references.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), deleted references to P.L. 1993, 1994, and 1995 in the first sentence.

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 adopted and subsequently amended (N.J.S.A. 17B:27A-17 et seq.), also referred to herein as the Small Employer Health Benefits Act.

"Affiliated carrier" means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another carrier.

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

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to

provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company authorized to issue health insurance, a health maintenance organization, a hospital service corporation, medical service corporation and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this chapter, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service corporation, hospital service corporation, or medical service 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, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

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

"Church plan" has the same meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(33)).

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

"Coinsurance cap" means the maximum amount a covered person is required to pay as a result of the application of the coinsurance under the standard plans, as set forth in the Appendix Exhibits to this chapter. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsurance cap.

"Coinsured charge limit" means, with respect to a preferred provider organization (PPO) plan, or a point of service (POS) plan, developed based on the standard health benefit plans set forth in the Appendix Exhibits to this chapter, the amount of covered charges a covered person must incur before no coinsurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsured charge limit.

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

"Copayment" or "copay" means a specified dollar amount a covered person must pay for specified covered charges.

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§1395 et seq.); Title XIX of the Federal Social Security Act (42 U.S.C. §§1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the Federal Social Security Act (42 U.S.C. §1396s); Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§1397aa through 1397jj); chapter 55 of Title 10, United States Code (10 U.S.C. §§1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §§8901 et seq.); a public health plan as defined by Federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. §§2504(e)); or coverage under any other type of plan as set forth by the Commissioner by regulation. Creditable coverage shall not include coverage consisting solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage, as specified in Federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

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

"Dependent" means the spouse or child of an eligible employee subject to applicable terms of the employee's health benefits plan. The reference to "spouse" includes a civil union partner pursuant to P.L. 2006, c. 103, and same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage, except that spouse shall be limited to spouses of a marriage as marriage is defined in the Federal Defense of Marriage Act, 1 U.S.C. §7, with respect to the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended. Thus, for purposes of COBRA, the term "spouse" does not include a civil union partner. At the option of the small employer, "spouse" includes a domestic partner pursuant to P.L. 2003, c.246.

"Eligible employee" means a full-time, bona fide 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, work on a temporary or substitute basis or are participating in an employee welfare arrangement pursuant to a collective bargaining agreement.

"Enrollment date" means, with respect to a person covered under a health benefits plan, the date of enrollment of the person in the health benefits plan or, if earlier, the first day of the waiting period for such enrollment. If an employee

changes plans or if the employer transfers coverage to another carrier, the covered person's enrollment date does not change.

"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. §§ 300 et seq.)

"Governmental plan" has the meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(32)) and any governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of that government.

"Group health plan" means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital or medical services 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), or any other similar contract, policy or plan issued to a small employer not explicitly excluded from the definition of health benefits plan. For purposes of this Act, "Health benefits plan" shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

"Health status-related factor" means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability.

"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, but only if the plan sponsor or carrier required such statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, death of a spouse, or divorce or legal separation or dissolution of a civil union or termination of a domestic partnership; 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; the individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be 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 or initially waived coverage under the policy for himself or herself and any then existing dependents provided the employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the policy within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.

"Maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as copayment,

deductible and coinsurance for all covered services and supplies in a calendar year. All amounts paid as copayment, deductible and coinsurance shall count toward the maximum out of pocket. Once the maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for covered services and supplies for the remainder of the calendar year.

"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.

"Medical care" means amounts paid:

1. For the diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; and

2. Transportation primarily for and essential to medical care referred to in paragraph 1 above.

"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.

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

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, as determined by the commissioner and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"Network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all services and supplies provided by network providers in a calendar year. All amounts paid as copayment, deductible and coinsurance shall count toward the network maximum out of pocket. Once the network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by network providers for the remainder of the calendar year. If a carrier wishes to use a common maximum out of pocket provision in a plan that has both network and non-network benefits, the network maximum out of pocket shall mean the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for all services and supplies provided by network providers and non-network providers in a calendar year. All amounts paid as copayment, deductible and coinsurance for both network and non-network services and supplies shall count toward the network maximum out of pocket. Once the network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by network or non-network providers for the remainder of the calendar year.

"Non-network maximum out of pocket" means the annual maximum dollar amount that a covered person must pay as deductible and coinsurance for all services and supplies provided by non-network providers in a calendar year. All amounts paid as deductible and coinsurance shall count toward the non-network maximum out of pocket. Once the non-network maximum out of pocket has been reached, the covered person has no further obligation to pay any amounts as copayment, deductible and coinsurance for services and supplies provided by non-network providers for the remainder of the calendar year.

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.

"Plan sponsor" has the meaning given that term under Title I of section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(16)(B)).

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be considered as a preexisting condition.

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

"Public health plan" means any plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two eligible employees on the first day of the plan year, and the majority of the eligible

employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (*o*) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer. Subsequent to the issuance of a health benefits plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of P.L. 1992, c.162 (N.J.S.A. 17B:27A-17 et seq.) that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in P.L. 1992, c.162 (N.J.S.A. 17B:27A-17 et seq.) to an employer shall include a reference to any predecessor of such 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 issued to small employers pursuant to N.J.S.A. 17B:27A-19.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board, described at N.J.A.C. 11:21-3.1, and set forth in the Appendix to this chapter.

"State" means the State of New Jersey.

"State approved HMO" is a health maintenance organization which is approved pursuant to P.L. 1973, c.337 (N.J.S.A. 26:21-1 et seq.).

"Stop loss" or "excess risk insurance" means an insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses wherein neither the employees nor other individuals are third party beneficiaries under the insurance policy. In order to be considered stop loss or excess risk insurance for purposes of the Small Employer Health Benefits Act, the policy shall establish a per person attachment point or retention or aggregate attachment point or retention, or both, which meet the following requirements:

1. If the policy establishes a per person attachment point or retention, that specific attachment point or retention shall not be less than $20,000 per covered person per plan year; and

2. If the policy establishes an aggregate attachment point or retention, that aggregate attachment point or retention shall not be less than 125 percent of expected claims per plan year.

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.228, effective April 11, 1994.
See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).
Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1994 d.583, effective October 27, 1994.
See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Added "Non-standard health benefits plan" and "Standard health benefits plan"; and amended "Act", "Commissioner", "Department", "Eligible employee", "Federally-qualified HMO", "Health benefits plan", "Small employer", "Small employer carrier", "Small employer health benefits plan", "State approved HMO", "Stop loss", and "Supplemental limited benefit insurance".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended "Dependent" and "Late enrollee"; added "Maximum out of pocket", "Network maximum out of pocket", and "Non-network maximum out of pocket".
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
In definition "Creditable coverage", inserted reference to "Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§1397aa through 1397jj)", inserted "a public health plan" and substituted "Federal" for "federal"; in definition "Enrollment date," added the last sentence; and added definition "Public health plan".
Amended by R.2008 d.132, effective April 24, 2008.
See: 40 N.J.R. 1746(a), 40 N.J.R. 2476(a).
In definition "Dependent", inserted the second and third sentences; and in definition "Late enrollee", inserted "or dissolution of a civil union".

11:21-1.3 Communications with the Board

All written communications with the SEH Board shall be submitted to the SEH Board at the following address:

New Jersey Small Employer Health Benefits
Program Board
20 West State Street, 10th Floor
PO Box 325
Trenton, New Jersey 08625-0325
Fax: (609) 633-2030

New Rule, R.1993 d.644, effective November 12, 1993.
See: 25 N.J.R. 4437(a), 25 N.J.R. 5668(a).
Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Changed address and added fax number.

11:21-1.4 Penalties

Failure of a carrier to comply with any provision of this chapter shall result in the imposition of penalties as authorized by law, including, but not limited to, penalties set forth at N.J.S.A. 17B:27A-41 and 17B:27A-43.

Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote the section.

11:21-1.5 Severability

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

Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).

11:21-1.6 Mission statement

The mission of the New Jersey Small Employer Health Benefits Program Board is to administer the New Jersey Small Employer Health Benefits Program in a manner aimed at increasing access to coverage, protecting consumers, educating key stakeholders in the marketplace and other interested parties, and promoting carrier participation in the market. This includes establishment and modification of standard plans for marketing to small employers and establishing and administering assessment mechanisms. It also includes the regulation of small employer health coverage carriers in conjunction with the New Jersey Department of Banking and Insurance and New Jersey Department of Health and Senior Services.

New Rule, R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

SUBCHAPTER 2. NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM PLAN OF OPERATION

11:21-2.1 Purpose and structure

(a) The Program has been created pursuant to section 12 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-28) as amended to assure the availability of the five standardized health benefits plans to New Jersey small employers, their eligible employees and the dependents of those eligible employees, on a guaranteed issue basis.

(b) The Board has been created pursuant to Section 13 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-29) to administer the Program reasonably and equitably under law.

(c) The Program Plan of Operation ("Plan") has been created in accordance with Section 14 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-30) to set forth as completely as possible the reasonable and equitable manner by which the Board will administer the Program under applicable law.

(d) The Program shall be administered by the Board. The Board shall administer the Program in accordance with the Plan developed and adopted by the Board pursuant to law, subject to the review and approval of the Commissioner of Insurance.

(e) The Board shall consist of 18 persons, including the Commissioners of Health and Senior Services and Banking and Insurance or their designees, both of whom shall serve ex officio, and 10 public members who shall be elected by the members of the Program, subject to approval by the Commissioner, and six public members who shall be appointed by the Governor with the advice and consent of the Senate. Initially, three of the elected public members of the Board shall be elected for a three year term, three shall be elected for a two year term, and three shall be elected for a one year term. The tenth elected public member, added by P.L. 1994, c.97, shall be elected for a three year term. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Thereafter, all public members of the Board shall be elected or appointed for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. No carrier shall have more than one representative on the Board, nor shall an HMO carrier and its affiliated insurance company, health service corporation, hospital service corporation, or medical service corporation have more than one representative on the Board.

(f) The following categories shall be represented among the elected public members:

1. Three carriers whose principal health insurance business is in the small employer market;

2. One carrier whose principal health insurance business is in the larger employer market;

3. A health, hospital or medical service corporation;

4. Two health maintenance organizations; and

5. Three persons representing small employers, at least one of whom represents minority small employers.

(g) The following categories shall be represented among the appointed public members:

1. Two insurance producers licensed to sell health insurance pursuant to N.J.S.A. 17:22A-1 et seq.;

2. One representative of organized labor;

3. One physician licensed to practice medicine and surgery in this State; and

4. Two persons who represent the general public and are not employees of a health benefits plan provider.

Amended by R.1995 d.65, effective February 6, 1995.
See: 26 N.J.R. 4310(a), 27 N.J.R. 585(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended (a); in (e), inserted "Of the two elected members... term of two years."; in (f)1, increased number from two to three; in (f)4, increased number from one to two; deleted (f)5 and (f)6, providing for risk-assuming carriers and reinsuring carriers; and recodified (f)7 as (f)5.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted a reference to P.L. 1993, c.162, section 6; and in (e), added ", nor shall an HMO carrier and its affiliated insurance company, health service corporation, hospital insurance corporation, or medical service corporation have more than one representative on the Board" at the end.

11:21–2.2 Definitions

The words and terms used in this Plan shall have the meanings set forth at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1.2 or as further defined below:

"Administrator" or "Executive Director" means that person, persons, or entity selected by the Board to effectuate the administrative functions of the Program.

"Deferral" means a deferment, in whole or in part, of payments by a member of any assessment issued by the SEH Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A–38 and N.J.A.C. 11:21–15.

"Earned premiums" means the premium earned in New Jersey on health benefits plans less returned premiums thereon.

"Plan of Operation" means the plan of operation of the Program, including articles, by-laws and operating rules approved by the Board pursuant to the Act.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "Reinsuring carrier" and "Risk-assuming carrier"; added "Non-standard health benefits plan", "Standard health benefits plan", and "Stop loss"; and amended "Board", "Commissioner", "Department", "Eligible employee", "Health benefits plan", "Member", "Small employer", "Small employer carrier", and "Small employer health benefits plan".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21–2.3 Powers of the Board

(a) The Board has the specific authority pursuant to the Act to:

1. Adopt rules and regulations to establish a voluntary risk pooling arrangement.

2. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Act;

3. Sue or be sued, including taking any legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims;

4. Establish benefit levels, deductibles and copayments, exclusions, and limitations for the standard health benefits plans in accordance with applicable law;

5. Establish additional policy forms by which a small employer carrier, other than a health maintenance organization, may provide indemnity benefits for health maintenance organization enrollees by direct contract with the enrollees' small employer through the issuance of dual contracts to the small employer;

6. Assess members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organization and reasonable operating expenses. Such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

7. Establish rules, conditions and procedures pertaining to the assessment of the members of the Program;

8. Establish a standard policy form for five standard health benefits plans and five rider packages, as provided in the Act;

9. Appoint from among the members appropriate legal, actuarial, and other committees as necessary to provide technical and other assistance in the operation of the Program, policy and other contract design, and any other functions within the authority of the Program;

10. Employ or retain such persons, firms or corporations to perform such functions as are necessary for the Board's performance of its duties. The Board may use the mailing address of such person, firm or corporation as the official address of the Program. Such persons may include an Administrator or Executive Director with such authority as may be delegated by the Board to implement and carry out broad directives of the Board made pursuant to statutory powers. Such persons may include actuaries, accountants, auditors, insurance producers and such other specialists or persons whose advise or assistance is deemed by the Board to be necessary to the discharge of its duties under the Act. The Board may agree to compensate such persons so as best to serve the interests of the Program and the public. Such persons, firms or corporations shall keep and maintain such records of their activities as may be required by the Board.

11. Develop a method of handling and accounting for assets and moneys of the Program and an annual fiscal reporting to the Commissioner;

12. Develop a means of providing for the filling of vacancies on the Board, subject to the approval of the Commissioner;

13. Address any additional matters which are appropriate to effectuate the provisions of this Act; and

14. Develop a buyers' guide or other informational material for the Program, and provide for a reasonable charge for the use and distribution of such informational material.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted a reference to reimbursement in 8, and inserted references to other informational material in 15.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), deleted 6 and recodified former 7 through 15 as 6 through 14.

11:21–2.4 Plan of Operation

(a) The Board shall perform its function under this Plan, and in accordance with the Act. The Plan is intended to assure the fair, reasonable and equitable administration of the Program and shall constitute a public record and accordance with the Act.

(b) The Plan does not, nor is it intended to, create any contractual or other rights or obligations between the Program and any entity or any person insured by any carrier. It does not provide any benefits or create any obligation, contractual or otherwise, to any person or entity.

11:21–2.5 Board structure and meetings

(a) The Program shall exercise its powers through a Board.

1. The Board shall be made up of the Commissioner, the Commissioner of Health and Senior Services, or their designees (who shall serve ex officio) and 16 public members. The composition of the Board shall be as described in N.J.S.A. 17B:27A–29 as amended. No person representing one of the public members shall serve, or continue to serve, on the Board unless such person represents one of the categories specified in N.J.S.A. 17B:27A–29 as amended.

2. Initially, three of the elected public members shall serve for a term of three years; three shall serve for a term of two years; and three shall serve for a term of one year. The tenth elected public member, added by P.L. 1994, c.94 shall be elected for a three year term. Of the two elected members added by P.L. 1995, c.298, that is, a health maintenance organization and a carrier whose principal health insurance business is in the small employer market, which new members shall replace the risk-assuming carrier and the reinsuring carrier, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Initially, of the six appointed public members added to the Board by P.L. 1994, c.97, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years. Thereafter, all public members shall serve for a term of three years. A vacancy in the membership of the Board shall be filled for an unexpired term in the manner provided for in the original election or appointment, as appropriate. The public directors shall serve their terms of office until their replacements are duly elected or pursuant to the terms of their appointments as applicable.

i. On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the Program members setting forth the time, date and place of the election meeting, stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

ii. Following the close of the nomination period, the Board shall determine from among the carriers and/or small employers representatives nominated those persons that are eligible and willing to serve in the position for which nominated. Carriers may be placed on the ballot for only one position, and may not hold more than one seat on the Board. If a carrier is nominated for two or more positions for which it is eligible, the carrier shall notify the Board as to the single position for which it will accept the nomination, and be designated on the ballot.

iii. At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote absentee on or before a date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

iv. Affiliated carriers shall have no more than one vote for each position subject to vote and no two affiliated carriers shall serve on the Board at the same time.

v. Elections shall be by the highest number of votes properly cast in person and absentee.

vi. The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:21–2.11.

3. The Board may elect a Chair and Vice Chair from among its Directors, as well as other officers, as it deems appropriate. The election of officers shall be held annually or more frequently if needed to fill vacancies. Subject to the provisions of the Act and as authorized by the Board, such officers are authorized to serve as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(b) The votes of the Board shall be on a one person, one vote basis. An elected public member, other than the three small employer representatives provided for in Section 13 of the Act (N.J.S.A. 17B:27A–29) as amended by P.L. 1994, c.97, and the Commissioners of Health and Senior Services and Banking and Insurance or their designees, may designate a voting alternate employed by the same carrier or same State agency, as appropriate. Appointed public members and the three small employer representatives, all of whom are appointed or elected as individuals, may not designate a voting alternate.

(c) A majority of the Directors shall constitute a quorum for the transaction of business. The acts of the majority of the Directors at a meeting at which a quorum is present shall be the acts of the Board, except as otherwise provided herein.

(d) A meeting of the Board shall be held no later than the first Tuesday in April each year in accordance with the State's Open Public Meetings Act.

(e) At least once each year, the Board shall meet to:

1. Review the Plan and submit proposed amendments, if any, to the Commissioner for review;

2. Review reports of the committees established by the Board;

3. Review and approve the rate of interest to be charged for late payments;

4. Review and approve changes in the communications program, as recommended by the Marketing and Communications Committee;

5. Determine whether any technical corrections or amendments to the Act should be recommended to the Commissioner;

6. Fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office; and

7. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the program.

(f) The Board shall hold other meetings upon the request of the Chair or three or more Directors, as deemed appropriate. A meeting may be held in person or by telephone. Notice of such a meeting and its purpose shall be provided to the general public and to the Directors in accordance with the State's Open Public Meetings Act.

(g) The Board shall keep reasonably comprehensive minutes of all its meetings showing the time and place, the Directors present, the subjects considered, the actions taken, the vote of each Director, and any other information required to be shown in the minutes by law. The original of the public record shall be retained by the Board or its agent and shall be promptly available to the public to the extent that making such matters public shall not be inconsistent with Section 7 of the Open Public Meetings Act (N.J.S.A. 10:4–12). At least two copies of the minutes of each meeting of the Board shall be delivered forthwith to the Commissioner; delivery to the Commissioner's designee on the Board shall satisfy this requirement.

(h) The Board may establish rules of the Program consistent with the Act and this Plan.

(i) Amendments to the Plan or suggestions for technical corrections to the Act shall require the concurrence of a majority of the entire Board.

(j) Directors shall not be compensated by the Program for their services but may be reimbursed for reasonable unreimbursed travel expenses incurred in attending Board and committee meetings pursuant to the State Travel Guidelines issued by the Department of the Treasury.

(k) The Board may adopt rules for the taking of testimony from the public, which may include rules relating to the time and place of any such public hearing, and reasonable rules for the length and format of testimony from individuals, groups and organizations.

(*l*) The Board may take up any additional matters which are appropriate to effectuate the provisions of this Act.

(m) The affirmative vote of at least two-thirds of the Directors present at a meeting shall be required to authorize assessments and the expenditure of Program funds.

Amended by R.1994 d.319, effective May 31, 1994.
See: 26 N.J.R. 1940(a), 26 N.J.R. 2587(a).
Amended by R.1995 d.65, effective February 6, 1995.
See: 26 N.J.R. 4310(a), 26 N.J.R. 4311(a), 27 N.J.R. 585(a).
Amended by R.1995 d.223, effective May 1, 1995.
See: 27 N.J.R. 438(a), 27 N.J.R. 438(b), 27 N.J.R. 1805(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, amended title of Commissioner and inserted additional P.L. references; in (a)2, inserted "Of the two elected members ... term of two years."; in (a)2iv, added restriction on affiliated carrier Board membership; and in (b), amended titles of Commissioners.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted references to P.L. 1994, c.97 and P.L. 1995, c.298 in 1, added the second and third sentences in 2ii, and deleted a reference to Secretaries in the first sentence of 3; rewrote (d); in (e), substituted a reference to the Commissioner for a reference to the Legislature at the end of 5; and in (g), added "; delivery to the Commissioner's designee on the Board shall satisfy this requirement" at the end.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a)2, amended N.J.A.C. reference; in (b), inserted "on" preceding "a one person" in the first sentence.

11:21–2.6 Committees

(a) Appointments to Standing and other committees shall be approved by a majority of the Board present. Each of

the Standing Committees shall include no more than seven directors, but the Board Chair may appoint additional persons, who need not be directors, as needed, with the approval of a majority of the Board. A written record of the proceedings of each committee shall be maintained by the Administrator or Executive Director. Committee members are responsible for providing staff support, but may recommend that the Board provide funding for outside contractors. Committees may not take final action; however, within the scope of their mission and duties, Committees may make recommendations and reports to the Board for its decision and action.

(b) Standing Committees shall include the following:

1. A Finance and Operations Committee which shall make recommendations to the Board with respect to:

i. The methods and rules for calculating assessments;

ii. Assessment of members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organizational and reasonable interim operating expenses;

iii. Independent consulting actuaries who may be approved by the Board;

iv. Establishment of rules, conditions, and procedures pertaining to the registry of multiple employer arrangements in accordance with the provisions of the Act; and

v. Oversight of studies necessary for development of reinsurance mechanisms;

vi. The Plan amendments thereto;

vii. The selection of an independent auditor for the annual audit of the Program operations;

viii. The review of reports prepared by independent auditors and other audit-related matters the Board deems necessary;

ix. Contracts which are necessary or proper to carry out the provisions and purposes of the Act;

x. Developing the means to select a Program Administrator or Executive Director, a statement of the powers and duties of the Administrator or Executive Director, the compensation of the Administrator or Executive Director, and a statement of the efficiency standards an Administrator or Executive Director must meet; and

xi. Recommendations for employing or retaining persons, firms or corporations to perform the functions necessary for the Board's performance of its duties, including retention of an Administrator or Executive Director for the Program;

2. A Legal Committee which shall make recommendations to the Board with respect to:

i. Appropriate interpretations of the Act, and such other matters as the Board may desire, including rules and regulations promulgated by the Board pursuant to the Act;

ii. Amendments to the Plan, and the various health benefits plans proposed by the Board for compliance with the Act, and by implication under Federal or other State legislation;

iii. Proposed amendments to the Act for Board approval;

iv. Contracts and legal documents for the Program;

v. All litigation and other disputes involving the Program and its operations;

vi. Maintenance of a written record of all written requests for a formal opinion of the Board received and responses provided by the Board.

vii. Coordination with legal counsel for the Board, as needed, on matters relating to the Program operations, including proposed contracts, operational practices, and statutory construction;

viii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the Program or a member;

ix. The Board's entering into contracts necessary or proper to carry out the provisions and purposes of the Act; and

x. Legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims and other matters related to lawsuits by or against the Board;

xi. Whether and how to respond to interpretations of the Board's rules made by carriers and inquiries and complaints received from consumers, policyholders, carriers or others.

(1) Recommendations by the Legal Committee may include a recommendation that the Board issue a statement interpreting its regulations, seek declaratory or injunctive relief as may be appropriate, or other administrative or legal remedies as may be available.

(2) In an effort to answer any inquiry or resolve any dispute or complaint, the Legal Committee, Administrator, or Executive Director may seek the input of other appropriate Committees in order to assist the Legal Committee in reaching a recommendation.

(3) The Legal Committee may refer matters as necessary to any other Committee which may also make recommendations to the Board.

3. A Marketing and Communications Committee which shall make recommendations to the Board with respect to:

i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of health benefits plans to eligible employees;

ii. Marketing and communication plans for the Program, as needed;

iii. Issues or concerns arising out of the marketing of Program coverage;

iv. The development of information concerning the Program to be released to the general public; and

v. Reviewing marketing material submitted by carriers in accordance with the Act; and

4. A Policy Forms Committee which shall make recommendations to the Board with respect to:

i. Optional benefit rider filings received pursuant to N.J.A.C. 11:21–3.2(d);

ii. Modifications to the standard health benefits plan policy forms and related forms;

iii. Interpretations of the standard health benefits plans and policy forms;

iv. Development of new standard health benefits plan policy forms as permitted by statute; and

v. Substantive and structural plan design issues.

(c) The Board may appoint other committees. The Board may by resolution adopted by a majority of the entire Board:

1. Determine the size of and appoint members to and/or fill any vacancy in any committee;

2. Appoint one or more persons to serve as alternate members of any committee, to act in the absence or disability of members of any committee with all the powers of such absent or disabled members;

3. Abolish any committees, in its discretion;

4. Remove any person from membership on any committee at any time, with or without cause; and

5. Authorize or appoint the use of consultants or other advisors to work with any committee.

(d) All committee members, including those committee members who are not also members of the Board, shall be subject to the Small Employer Health Benefits Program Code of Ethics adopted by the Board pursuant to the requirements of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D–12 et seq. Committee members who are not also members of the Board shall be required to file a Certification, in a form to be provided by the Board, stating that they, and the respective entities and/or carrier by whom they are employed, agree to be subject to all applicable terms set forth in the Code of Ethics.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), increased maximum number of directors on Standing Committees from five to seven and inserted text "who need not be directors" following "appoint additional members"; substantially amended (b); and added (d).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), substituted a reference to the Administrator or Editorial Director for a reference to a Secretary at the end of the third sentence; in (b)1, deleted a former iii, recodified former iv through xii as iii through xi, and inserted references to the Executive Director throughout the new x and xi; in (b)2xi(2), inserted a reference to the Executive Director; and in (b)4ii, changed N.J.A.C. reference, and added a reference to Exhibit BB, Part 6 fillings at the end.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b)4, deleted ii and iii and recodified former iv through vii as ii through v.

11:21–2.7 Administrator or Executive Director selection and duties

(a) The Administrator or Executive Director shall be selected by the Board.

(b) The Administrator or Executive Director shall perform the administrative functions required under the Act and the Plan. The Administrator or Executive Director is responsible, along with the Board, for the fair, equitable and reasonable administration of the Program.

(c) The Administrator or Executive Director shall perform all administrative functions developed by the Board including the following:

1. Preparing and submitting an annual report to the Board and the Commissioner no later than September 1; preparing and submitting monthly reports to the Board;

2. Establishing the procedures and installing the systems needed to properly administer the operations of the Program;

3. Establishing with Board approval, one or more depository accounts for the transaction of Program business;

4. Collecting assessments due to the Program on a timely basis;

5. Depositing all moneys collected on behalf of the Program on a timely basis in the State Treasury in an account established for that purpose;

6. Issuing checks or drafts, on and or approving charges against bank accounts of the Program;

7. Keeping all accounting, administrative and financial records of the Program;

8. Acting as a resource for carriers in complying with the Program;

9. Calculating all assessments in accordance with the methodology approved by the Board; notifying members of amounts due; tracking the amount of assessments in dispute or subject to deferral request; coordinating with

the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters;

10. Preparing an annual estimate of the operating and administrative expenses of the Program; and

11. Performing other functions as agreed between the Board and the Administrator or Executive Director.

(d) The Administrator or Executive Director shall maintain calendar year records of premiums, reimbursements, and fiscal year operating and administrative expenses of the Program and shall retain these records for a period of seven years following the end of such calendar year or as otherwise required pursuant to N.J.S.A. 47:3-15 et seq.

(e) The Board may select, and establish compensation for, such other staff as may be necessary for the administration of the Program.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Reworded (d)5; deleted (d)6, relating to reimbursing reinsuring carriers; recodified (d)7 through (d)12 as (d)6 through (d)11; in (d)8, deleted reference to reinsuring carrier; deleted (d)13, relating to reviewing for compliance; and recodified (d)14 as (d)12.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Inserted references to the Executive Director throughout; deleted a former (b); recodified former (c) through (f) as (b) through (e); in the new (c), changed the deadline for the annual report from the third week in July to September 1 in 1, deleted a former 11, and recodified former 12 as 11; and in (d), substituted a reference to fiscal year operating and administrative expenses of the Program for a reference to operating and administrative expenses.

11:21-2.8 Assessments for administrative and operating expenses

(a) Within 45 days after approving a final audited Program statement, the Board shall determine the final administrative expense total for the fiscal year, if any.

1. Each member's final assessment shall be reduced by any interim assessment paid by the member or credited to the member by the Board.

2. Each member's final assessment shall be reduced by any deferred assessments paid by assessed carriers in proportion to the original additional assessment made to cover the deferred amount.

3. Members shall be assessed for a proportionate share of the final administrative expenses for the fiscal year on the basis of health benefits plan earned premiums for the calendar year that includes the first six months of the fiscal year. The administrative expense assessment for each member shall be equal to the total of all administrative expenses for the fiscal year multiplied by the ratio of that member's earned premium for health benefits plans to the earned premium for health benefits plans of all members of the calendar year that includes the first six months of the fiscal year.

i. Beginning in Fiscal Year 2005, if a member's proportionate share of the interim assessment or final administrative assessment is less than $5.00, the carrier shall not be assessed and the amounts uncollected will be reapportioned proportionally, based on market share, among the member carriers.

(b) The Board may make an interim assessment of members for reasonable and necessary organizational expenses and to cover anticipated interim operating expenses. At the discretion of the Board, interim assessments may be made on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses.

(c) Assessment amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, SEH Program, and mailed to the Executive Director at the address in N.J.A.C. 11:21-1.3.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 45 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid as permitted by N.J.S.A. 17B:27A-32c.

i. The interest rate shall be 1.5 percent of the assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment, for which an interest penalty amount has accrued, shall include the interest penalty amount accrued as of the invoice date; otherwise, payment shall not be considered to be in full.

2. Carriers that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the Board, shall be assessed for and make payment of the full amount of the assessment invoice, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that carrier, or, if a contested case, the Board has rendered a final determination in favor of that carrier in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

3. A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:21-15.

i. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice to be held in an interest bearing account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

ii. If the member withholds payment, as permitted herein and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth herein, accruing from the date of the invoice for the assessment.

4. Amounts deferred by the Commissioner or subject to dispute, which dispute is resolved in favor of the carrier, shall be redistributed among all other members proportionately.

(d) The Administrator or Executive Director shall coordinate with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters, and develop appropriate procedures for such matters, and disburse funds for administrative expenses upon the directive of the Board.

1. Amounts of assessment in dispute or subject to deferral request, including any interest penalty paid by a carrier pursuant thereto, shall not be disbursed by the Administrator or Executive Director until such time as the dispute has been settled against the disputing carrier, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed immediately according to Board directive.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing carrier, or a deferral is granted, shall be returned to the appropriate carrier within 15 days of the date that the Administrator or Executive Director receives notice of the determination by the Board or the Commissioner, as applicable along with the proportionate amount of interest penalty, if any, paid by the carrier for late payment of the amount.

(e) A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Administrator or Executive Director in order to preserve its right to the moneys owed and paid pursuant to the invoice for assessment.

(f) If a member determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State or to take such other action against the carrier as may be authorized by law. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

Amended by R.1997 d.62 effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), substituted "July 15" for "April 15".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), rewrote the introductory paragraph and 3; rewrote (c); and in (d) and (e), inserted references to the Executive Director throughout.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Added (a)3i; in (c), inserted an N.J.S.A. reference at the end of 1 and deleted "escrow" following "interest bearing" in 3i.

11:21–2.9 Reporting requirements

Carriers shall submit statements, assessments and other reports as may be required by the Board pursuant to the Act.

Recodified from 11:21–2.10 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Section was "Assessment for reimbursable losses".

11:21–2.10 Financial administration

(a) The Board shall maintain the books and records of the Program so that financial statements can be prepared to satisfy the Act. Further, these books shall satisfy any additional requirements of the Board and outside auditors.

1. The receipt and disbursement of cash by the Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when assets or liabilities should be realized by the Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the Program shall be calculated for each carrier and confirmed as deemed appropriate by the Board or when requested by the respective carrier. These balances should be supported by a record of each individual carrier's financial transactions with the Program. These records include:

i. Any adjustments to assessments as explained in this Plan;

ii. Adjustments to the amount due to/from the Program based upon corrections to carrier submissions;

iii. Interest charges due from a carrier for late payment of amounts due to the Program; and

iv. Other records required by the Board.

5. The Board shall maintain a general ledger which balances are used to produce the Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

6. The Board's fiscal year shall begin on July 1 and end on June 30.

7. Assessments shall be paid when billed. If the assessment is not received by the Board within 45 days of the invoice date, the carrier shall pay interest on the assessment from the invoice date at the rate of 1.5 percent per month except if the carrier is granted a deferral.

(b) All funds of the Program shall be deposited in, and all disbursements made from, the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget, and all financial records shall be kept in a form acceptable to the Office of Management and Budget.

1. Funds of the Program shall be deposited into a dedicated account within the General Fund.

2. Moneys shall be credited from the General Fund, with the approval of Director of the Division of Budget and Accounting to the Program's bank accounts upon request by the Board through the Department.

3. The Administrator or Executive Director shall make such requests for funds as directed by the Board and shall deposit all moneys received from the Treasury in a Board bank account.

(c) A bank checking account and interest-bearing investment accounts shall be established separately in the name of the Program and shall be approved by the Board.

1. The Board shall authorize individuals to sign checks on behalf of the Board.

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law. All investment income earned shall be credited to the Program and shall be applied to reduce future assessments of members for the Program administrative expenses.

Recodified from 11:21-2.11 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a)4i, relating to net losses; recodified former (a)4ii through (a)4v as (a)4i through (a)4iv; inserted new (a)6; recodified former (a)6 as (a)7; in (b)2, deleted reference to including in the request justification for the request; and in (c), inserted reference to interest-bearing investment. Former section recodified to N.J.A.C. 11:21-2.9.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (b)3, inserted a reference to the Executive Director; and in (c)2, deleted a reference to Program losses in the last sentence.

11:21-2.11 Records

(a) The Board shall provide for the maintenance and retention of its official records in accordance with the Destruction of Public Records law (N.J.S.A. 47:3-15-32) and all other applicable laws.

(b) The Board's records shall include the following:

1. Minutes of all Board meetings;

2. Written reports and recommendations of committees to the Board;

3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules;

4. Riders proposed or adopted by the Board, including all comments received;

5. The Plan of Operation and any amendments thereto;

6. Records concerning the election of Directors and appointment of committees and committee members;

7. Regulations or actions proposed or adopted by the Board, including all comments received; and

8. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to the "Right-to-Know" Law (N.J.S.A. 47:1A-1 et seq.) except that information in filings determined by the Board or the Department by regulation to be confidential and proprietary shall not be subject to public inspection and copying, and except that written communications of the Board, its staff, or committees, including, but not limited to, reports, opinions, and recommendations, where such communications contain discussion of litigation strategy, attorney-client advice or other privileged information, shall not be available for public inspection and copying.

Recodified from 11:21-2.12 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-2.10.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote (c).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted (d).

11:21-2.12 Audit functions

(a) The Program shall have an annual audit of its operations conducted by an independent certified public accountant approved by the Board. This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for the Program; and

2. The annual fiscal report of the Program.

Recodified from 11:21-2.13 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a), relating to necessity and frequency of audits; recodified former (b) as (a); deleted (a)3, relating to calculation and collection of assessments for net losses. Former section recodified to N.J.A.C. 11:21-2.11.

11:21–2.13 Penalties/adjustments and dispute resolution

(a) Numerous factual determinations and tasks shall be performed by carriers relative to their participation in the Program. It is expected that all carriers will exercise good faith and due diligence in all aspects of their relationship with the Program. Errors may occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

1. Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, except as provided herein.

2. All other additional sums due to the Program as a result of errors made by carriers shall be paid immediately, with interest.

3. If the Board determines that the nature or extent of errors made by a particular carrier evidences gross negligence or intentional misconduct, the Board may, after notice, recommend to the Commissioner, Attorney General, and other appropriate officials, penalties and sanctions as may be appropriate in accordance with the Act.

4. All interest payments required under this Plan shall be calculated at 1.5 percent per month, from the date the incorrect payment occurred or a payment should have been made, through the date the correct payment is made. Errors reported by carriers within 60 days of their occurrence shall not be subject to interest.

(b) A carrier seeking to challenge the amount of an assessment shall do so within 20 days of receiving the notice of assessment following the procedures in (d) below.

(c) A carrier which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the Board consistent with the appeals procedures set forth at N.J.A.C. 11:21–2.17.

Recodified from 11:21–2.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–2.12.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (e), substituted a reference to 45 days for a reference to 30 days in the first sentence.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote (c); deleted (d) and (e).

11:21–2.14 Indemnification

(a) A member or employee of the Board, including the Administrator or Executive Director and staff, shall not be liable in an action for damages to any person for any action taken or recommendation made by him or her within the scope of his or her functions as a member or employee, if the action or recommendation was taken or made without malice.

(b) The members of the Board shall be indemnified and their defense of any action provided for in the same manner and to the same extent as employees of the State under the "New Jersey Tort Claims Act," P.L. 1972, c.45, on account of acts or omissions in the scope of their employment.

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–2.13.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted a reference to the Executive Director.

11:21–2.15 Amendment and termination

(a) This Plan may be amended by a majority vote of the entire Board, subject to approval of the Commissioner as provided hereinafter. A vote on an amendment may be taken at any meeting called, in whole or in part, for the purpose of considering a proposed amendment. Written notice of any meeting at which an amendment to the Plan is to be considered shall be sent to each Director by mail or facsimile transmission at least 10 days (exclusive of the meeting day) prior to the date of the meeting. Such notice shall state that an amendment to the Plan is to be considered at the meeting and shall set forth the substance of any amendments which have been proposed or a description of the section or sections which are proposed to be amended. Notice to a Director shall be deemed sufficient if mailed, postage prepaid, to the most recent address provided by the Director to the Board or sent by facsimile transmission to the most recent facsimile reception number provided by the Director. At any meeting for the consideration of an amendment to the Plan, for which proper notice has been given pursuant to this section, the Board may vote on any amendment proposed by a Director prior to, or during the meeting. Any amendment adopted by the Board shall be submitted to the Commissioner for approval. Any such amendment submitted to the Commissioner shall be deemed approved no later than 90 days after receipt by the Commissioner unless expressly disapproved in writing by the Commissioner before expiration of the approval period. Amendments to the Plan must be adopted pursuant to P.L. 1993, c.162.

(b) The Program shall continue in existence subject to termination in accordance with the laws of this State or the United States of America. In case of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the Program, the Program shall terminate and conclude its affairs. Any funds or assets held by the Program following the payment of all claims and expenses of the Program shall be distributed to the members at that time in accordance with the then-existing assessment formula.

Recodified from 11:21–2.16 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Section was "Indemnification".

11:21-2.16 (Reserved)

Recodified to 11:21-2.15 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

11:21-2.17 Appeals

(a) If the Board denies a member's request for relief made pursuant to this chapter, or if the member objects to the terms of the relief granted, the member may request a hearing on the Board's determination within 20 days from the date of receipt of such determination as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, daytime telephone number, and fax number of a contact person familiar with the matter;

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the material facts in dispute and describing the basis for which the member believes that the Board's findings of fact are erroneous.

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are material issues of fact in dispute.

3. The Board shall, within 45 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. If the Board finds that the matter constitutes a contested case, it shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. In a matter which has been determined to be a contested case, if the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

ii. If the Board finds that the matter does not constitute a contested case, it may, with the approval of the Director of the Office of Administrative Law, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21. If the Board finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

New Rule, R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

11:21-3.1 Benefits provided

(a) The standard 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 and V;

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

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

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

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

6. Exhibit F contains those items of Plans B, C, D and E which are common among the plans as well as text which is unique to Plans B, C, D and E, where such Plan unique text is clearly identified;

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

8. HMO/POS Plan, "The Small Group Health Maintenance Organization Point of Service ("POS") Contract," Exhibit HH and II.

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

1. Plan A shall contain a deductible of $250.00 per covered person and:

i. $500.00 per covered family, to be satisfied by two separate covered persons and a per person maximum out of pocket of $7,750; or

ii. $750.00 per covered family, to be satisfied on an aggregate basis and a per person maximum out of pocket of $7,750.

2. Plans B, C, and D shall contain annual deductible provisions consistent with the following specifications:

i. The per covered person annual deductible shall be an amount not less than $250.00 and not greater than $5,000.

ii. The per covered family annual deductible shall be, at the option of the carrier, either:

(1) Two times the per covered person annual deductible, and may either be satisfied by two separate covered persons or on an aggregate basis; or

(2) Three times the per covered person annual deductible and must be satisfied on an aggregate basis.

3. Plans B, C, and D shall contain maximum out of pocket provisions consistent with the following specifications:

i. The per covered person maximum out of pocket for Plan B shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

ii. The per covered person maximum out of pocket for Plan C shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

iii. The per covered person maximum out of pocket for Plan D shall be the sum of the annual deductible and an amount not less than $2,000 and not greater than $10,000.

iv. The per covered family maximum out of pocket shall be at the option of the carrier, either:

(1) Two times the per covered person maximum out of pocket, and may either be satisfied by two separate covered persons or on an aggregate basis; or

(2) Three times the per covered person maximum out of pocket and must be satisfied on an aggregate basis.

4. Plan E shall contain a deductible of $150.00 per covered person and:

i. $300.00 per covered family, to be satisfied by two separate covered persons, with a per person maximum out of pocket of $1,650, and a family maximum out of pocket of $3,300 to be satisfied by two separate covered persons; or

ii. $450.00 per covered family, to be satisfied on an aggregate basis, with a per person maximum out of pocket of $1,650, and a family maximum out of pocket of $4,950 to be satisfied on an aggregate basis.

(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 one or more of the following plan designs using copayments and may, at the option of the HMO members, also offer HMO plans using deductible and coinsurance provisions. All options offered by the HMO member shall be made available to every small employer seeking coverage. Specifications for the use of copayments are set forth in (c)1 below. Specifications for the use of deductible and coinsurance are set forth in (c)2 below. Specifications for features that are common to plans that use copayment and plans that use deductible and coinsurance are set forth in (c)3 below.

1. Copayment Design:

i. The hospital inpatient copayment shall be: $75.00; $100.00; $150.00; $200.00; $300.00; $400.00; or $500.00.

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, pre-natal care and prescription drugs shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00, respectively.

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $250.00 and not greater than $2,500 per person. The covered family deductible shall be two times the per person deductible and may, at the option of the HMO, either be satisfied by two separate covered persons or may be satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies or prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in five percent increments.

iv. The maximum out of pocket shall be a dollar amount not to exceed $5,000, and for a covered family shall not exceed two times the per person maximum out of pocket.

3. Common Features:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall be, at the option of the carrier, $50.00, $75.00 or $100.00.

ii. The pre-natal care/maternity copayment, which shall only be required at the initial visit, shall be, at the option of the carrier, either $25.00, or equal to the copayment applicable to a primary care physician visit.

iii. Prescription drugs covered under the HMO plan, as opposed to under a separate prescription drug rider, shall be subject to 50 percent coinsurance, or a $15.00 copayment, at the option of the HMO.

(d) The standard health benefits Plans B, C, D and E and optional riders may be offered through or in conjunction with a selective contracting arrangement approved pursuant to P.L. 1993, c.162, section 22. The standard health benefits Plans B, C, D and E and optional riders may be offered with the same selective contracting arrangement by a carrier that is exempt from the requirements of P.L. 1993, c.162, section 22, pursuant to N.J.A.C. 11:4–37.1(b), but which is permit-

ted to enter into agreements with participating providers pursuant to any statute. Plans issued through an approved selective contracting arrangement and plans with selective contracting arrangement features issued by an entity exempt from the requirements shall be subject to the following:

1. All of the requirements of N.J.A.C. 11:4–37.3(b)6;

2. The network annual deductible shall be an amount not less than $250.00 and not greater than $2,500 per covered person, and for a covered family shall not exceed two times the per covered person annual deductible, satisfied on either an individual basis or on an aggregate basis. If a carrier elects to use a common annual deductible for both network and non-network benefits, the network annual deductible amount shall apply to both network and non-network services and supplies;

3. The network maximum out of pocket shall not exceed $5,000 per covered person, and for a covered family shall not exceed two times the per covered person maximum out of pocket. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies;

4. The non-network annual deductible shall be no more than three times the network annual deductible per covered person, and for a covered family shall equal two times the per covered person annual deductible;

5. The non-network maximum out of pocket shall be no more than three times the network maximum out of pocket per covered person, and for a covered family shall equal two times the per covered person maximum out of pocket; and

6. The HMO Plan standard copayment levels for practitioner visits, emergency room and hospital confinements may be substituted for deductibles applicable to network benefits.

(e) The standard 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 coinsurance, the network benefit shall not be subject to coinsurance;

2. For those services which are subject to 50 percent coinsurance, the network coinsurance shall be 30 percent;

3. The network maximum out of pocket shall not exceed $5,000 per covered person. If a carrier elects to use a common maximum out of pocket for both network and non-network benefits, the network maximum out of pocket amount shall apply to both network and non-network services and supplies; and

4. The non-network maximum out of pocket shall be no more than three times the network maximum out of pocket per covered person.

(f) An insurer with an approved selective contracting agreement, like all other carriers, shall offer the standard health benefits plans, whether as indemnity plans or through or in conjunction with a selective contracting arrangement, in all geographic areas in the State.

1. If an insurer's approved service area for its selective contracting arrangement includes all geographic areas in the State, the insurer shall offer the standard health benefits plans as either indemnity plans or through or in conjunction with a selective contracting arrangement, or both, in all geographic areas in the State.

2. If an insurer's approved service area for its selective contracting arrangement does not include all geographic areas in the State, the insurer shall offer:

i. The standard health benefits plans as indemnity plans in all areas in the State not included in its approved service area; and

ii. The standard health benefit plans as either indemnity plans or in conjunction with a selective contracting arrangement, or both, in all geographic areas within its approved service area.

3. If an insurer with a limited approved service area chooses to offer the standard health benefit plans only through or in conjunction with a selective contracting arrangement in its limited approved service area, and later receives approval for its selective contracting arrangement in additional geographic areas in the State, the insurer shall not be required to offer the standard health benefits plans as indemnity plans in the newly approved areas, but shall be required to renew the in force standard health benefits plans in the newly approved service areas.

(g) A carrier that is exempt from the requirements of P.L. 1993, c.162, section 22, pursuant to N.J.A.C. 11:4–37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute shall offer the standard health benefits plans whether as indemnity plans or as PPO or POS plans in all geographic areas of the State.

1. If such a carrier has agreements with participating providers in all geographic areas of the State, the carrier shall offer the standard health benefits plans either as indemnity plans or as PPO or POS plans or any such combination in all geographic areas of the State.

2. If such a carrier has agreements with participating providers only in certain geographic areas of the State, the carrier shall offer:

i. The standard health benefits plans as indemnity plans in all geographic areas of the State where it does not have agreements with participating providers; and

ii. The standard health benefits plans whether as indemnity plans or as PPO or POS plans or any such combination in all geographic areas of the State where it has agreements with participating providers.

3. If such a carrier which has agreements with participating providers only in certain geographic areas of the State chooses to offer the standard health benefits plans only as PPO or POS plans in such areas and later expands the area in which it has agreements with providers, the carrier shall not be required to offer the standard health benefits plans as indemnity plans in the expanded area, but shall be required to renew the in force standard health benefits plans in the newly expanded area.

(h) State approved and Federally qualified HMO members may offer the HMO POS plan, as set forth in Exhibit HH of the Appendix, so long as the member is in compliance with N.J.A.C. 8:38–14, which regulations set forth requirements for HMOs offering indemnity benefits. HMO members offering the HMO POS plan may offer the following arrangements set forth in (h)1, 2 and 3 below with respect to their network services and supplies. The non-network deductible, coinsurance and maximum out of pocket must comply with N.J.A.C. 11:21–3.1(d).

1. Copayment Design:

i. The hospital inpatient copayment shall be: $75.00; $100.00; $150.00; $200.00; $300.00; $400.00; or $500.00.

ii. The copayment for all services and supplies other than hospital inpatient, emergency room, pre-natal care and prescription drugs shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00, respectively.

2. Deductible and Coinsurance Design:

i. The copayment for primary care physician services shall be: $5.00; $10.00; $15.00; $20.00; $30.00; $40.00; or $50.00.

ii. The cash deductible, which shall not apply to primary care physician visits, preventive care, immunizations and lead screening for children, pre-natal care or prescription drugs shall be an amount not less than $250.00 and not greater than $2,500 per person. The covered family deductible shall be two times the per person deductible and may, at the option of the HMO, either be satisfied by two separate covered persons or may be satisfied on an aggregate basis.

iii. The coinsurance, which shall not apply to services to which a copayment applies or prescription drugs, shall be a percentage between 10 percent and 50 percent, inclusive, in five percent increments.

iv. The maximum out of pocket shall be a dollar amount not to exceed $5,000 and for a covered family shall not exceed two times the per person maximum out of pocket.

3. Common Features:

i. The emergency room copayment, which shall be paid in addition to other copayments, deductible and coinsurance, shall be, at the option of the carrier, $50.00, $75.00 or $100.00.

ii. The pre-natal care/maternity copayment, which shall only be required at the initial visit, shall be, at the option of the carrier, either $25.00, or equal to the copayment applicable to a primary care physician visit.

iii. Prescription drugs covered under the HMO–POS plan, as opposed to under a separate prescription drug rider, shall be subject to the non-network deductible and coinsurance.

Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), (d), and (e), substituted "standard health benefits plan" for "small employer health benefits plan"; added (a)8; in (d), deleted reference to HMO Plan; in (d)3, deleted reference to out-network benefits; and added (f) through (h).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), changed Exhibit references throughout, and added "as well as text which is unique to Plans B, C, D and E, where such Plan unique text is clearly identified" at the end of 6; in (b), substituted a reference to Exhibits A, F, V and W for a reference to Exhibits A through F in the introductory paragraph; and in (d), rewrote the introductory paragraph and 1, and substituted a reference to Exhibits F and G for a reference to Exhibits B through G in 2.
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
In (b), inserted a new 3, and recodified former 3 as 4; inserted (c)4; and in (h), substituted "non-biologically based mental illness" for "mental/nervous and substance abuse" following "$200.00" in 4, and added 5.
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote (b) through (d); in (e), added 3 and 4; rewrote (h).

11:21–3.2 Optional benefit riders to standard plans and administrative functions

(a) Members that offer health benefits Plans B, C, D and E may offer one or more of the standard 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 standard health benefits plan (Plan B, C, D, E, HMO plan, or HMO POS 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 standard 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 standard optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select the following rider, set forth at Exhibit H, to be offered with each health benefits Plan (Plan B, C, D or E):

i. Mail order and card;

ii. Card only; or

iii. Mail order only; and

2. Replacement prescription drug benefits for the HMO Plan or the HMO POS Plan. The carrier may select the following rider, set forth at Exhibit H, to be offered with the HMO or HMO POS health benefits plan:

i. Mail order and card;

ii. Card only; or

iii. Mail order only.

(d) In addition to the standard optional benefit riders listed in (c) above, members may offer riders that revise in any way the coverage offered by Plans A, B, C, D, E, HMO, and HMO POS plan subject to the provisions set forth in (d)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that decreases any one benefit or decreases the actuarial value of Plans A, B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof for informational purposes with the Board, and for approval by the Commissioner. No rider filed with the Commissioner may be sold until approved by the Commissioner.

2. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans A, B, C, D, E, HMO, or HMO POS, the member shall file the rider or amendment thereof with the Board for informational purposes.

3. "Coverage" offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above includes, but is not limited to:

i. The types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations" and "Exclusions" sections of Plans A, B, C, D, and E the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan, and the "Covered Services and Supplies," "Covered Charges," "Covered Charges with Special Limitations," "Non-Covered Services and Supplies and Non-Covered Charges" sections of the HMO POS plan;

ii. Deductibles, Coinsurance, Copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans A, B, C, D, E, HMO, and HMO POS as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carryover, and first dollar coverage), and their applicability in situations involving common accident; and

iii. Eligibility as set forth in the "Employee coverage," "Dependent coverage" and "Continuation rights" sections of Plans A, B, C, D, and E, the "Eligibility" and "Continuation Provisions" of sections of the HMO plan, and the "Eligibility" and "Continuation Rights" sections of the HMO POS plan.

4. "Coverage" offered by the five plans, the HMO plan, and the HMO POS plan for purposes of optional benefit riders filed pursuant to (d)2 above does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:21–1.2, except for dental coverage where the additional dental coverage is subject to the standard plan's deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:21–1.2.

5. In addition to (d)1, 2, 3 and 4 above, any benefit rider or amendments thereof shall be subject to the provisions of Sections 2, 3(b), 6, 7, 8, 9 and 11 of P.L. 1992, c.162.

6. A member making an informational filing to the Board pursuant to (d)2 above shall:

i. Submit one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:21–1.3;

ii. Submit one copy of the rider or riders which amend the standard group policy and certificate forms, which rider or riders shall include cross-references to the standard group policy and certificate provisions or sections and/or pages which are being modified;

iii. Specify whether the rider or amendment thereof is to be used in connection with standard health benefit Plans A, B, C, D, E, HMO, or HMO POS plan and provide clear and conspicuous notice of such on the forms submitted for each rider;

iv. The standard group policy and employee certificate language shall not be altered, and the benefit modifications shall appear only on the rider or riders;

v. Submit copies of the standard group policy and certificate page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

vi. For riders of increasing value only, submit copies of a certification signed by a duly authorized officer of the member that states clearly:

(1) That the rider or amendment thereof increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan A, B, C, D, E, HMO, or HMO POS;

(2) That the filing is complete and in accordance with all the requirements of this subsection and applicable New Jersey statutes and regulations;

(3) That the member will offer the rider or amendment thereof to any small employer seeking to purchase the health benefits plan it modifies;

(4) That a rate filing for the rider has been made with the Commissioner pursuant to N.J.A.C. 11:21-9; and

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement or the HMO POS contract, that the plan as ridered continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and N.J.A.C. 8:38-14.4(c), as applicable.

7. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in compliance with this subsection, within 45 days of the Board's receipt of the member's submission of a rider or amendment thereof. If the Board does not notify a member of its determination with respect to an informational filing within 45 days of the Board's receipt of the submission, the informational filing shall be deemed complete.

i. If an informational filing is incomplete and not in compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing. Upon receipt of notice from the Board that a filing is incomplete and not in substantial compliance with the requirements of this subchapter, the member shall not sell the rider or amendment thereof until the member has received written notice from the Board that the informational filing is complete.

ii. If the Board takes no action within 45 days of receipt by the Board of a member's submission of information requested by the Board to complete an informational filing, the filing shall be deemed to be complete.

(e) A carrier may provide for alternative means of administering aspects of the standard forms which administration does not affect the benefits provided in the standard policy forms and riders. Administration includes, but is not limited to, administration of claims, COBRA, premium collection, and issue functions. The delegation of administrative functions shall be achieved by a separate contract between the carrier and/or the small employer, and a third party. Such arrangements shall not alter the standard group policy and certificate language.

(f) All carriers shall file, by March 1 of each year, Exhibit BB Part 6, on which all optional benefit riders are identified, regardless of whether or not the carrier has filed optional benefit riders. Carriers shall include in such filing information that is current through December 31 of the prior year.

Amended by R.1994 d.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Amended by R.1995 d.116, effective March 6, 1995.
See: 26 N.J.R. 4729(a), 27 N.J.R. 918(a).
Amended by R.1995 d.630, effective December 4, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3118(a), 27 N.J.R. 4895(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted "standard" preceding "optional benefits riders" and inserted reference to HMO POS throughout; in (a), inserted "standard" preceding "health benefits plan"; in (d)3i, added text "and the 'Covered Services and Supplies,' ... HMO POS plan"; in (d)3iii, inserted reference to Eligibility and Continuation Rights sections of the HMO POS plan; in (d)4ii and (d)5, deleted reference to vision coverage and benefits; in (d)7i, amended submission requirements and added (d)7vi(5).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (d), deleted a reference N.J.A.C. 11:21-12 in 1, deleted a former 5, recodified former 6 through 8 as 5 through 7 and made a corresponding internal reference change, added "For riders of increasing value only," at the beginning of vi and deleted "plan not approved by the Commissioner" at the end of vi(1) in the new 6; and added (f).
Amended by R.2003 d.24, effective January 21, 2003 (operative June 1, 2003).
See: 34 N.J.R. 648(a), 35 N.J.R. 442(a).
Rewrote (c).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), inserted ", or HMO POS plan" preceding "as applicable"; in (d), rewrote 3ii, deleted "an original" preceding "one copy" in 6i, substituted "one copy" for "copies" preceding "of the rider" in 6ii and rewrote 7; in (f), added the last sentence.

SUBCHAPTER 3A. NON-STANDARD HEALTH BENEFITS PLANS

11:21-3A.1 Purpose and scope

This subchapter establishes the conditions under which non-standard health benefits plans may be issued, renewed or continued pursuant to P.L. 1995, c.340, and specifies the rules which shall apply to the issuance, renewal or continuation of a non-standard health benefits plan.

11:21-3A.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.2 unless defined below or the context clearly indicates otherwise:

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by a carrier, whether directly or through an association, multiple employer arrangement or out-of-State trust, prior to January 1, 1994, and which was in effect on February 28, 1994, regardless of whether the association, multiple employer arrangement, or out-of-State trust changed the issuing carrier between March 1, 1994 and January 5, 1996.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board described at N.J.A.C. 11:21-3.1, and set forth in the Appendix to this chapter.

11:21-3A.3 Renewal of non-standard health benefits plans

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall renew or continue a non-standard health benefits plan at the option of the small employer policy or contract holder, unless that plan is withdrawn by the carrier pursuant to N.J.A.C. 11:21-16, subject to the following:

1. The non-standard health benefits plan shall comply with the provisions of N.J.S.A. 17B:27A-18, 17B:27A-19b, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27.

2. The non-standard health benefits plan shall comply with all applicable rating and loss ratio requirements, and shall comply with all regulations adopted by the Commissioner pursuant to P.L. 1995, c.340, § 7; and

3. The non-standard health benefits plan, if issued by a carrier through an out-of-State trust:

i. Shall offer benefits that are at least equal to the actuarial value and benefits coverage of the least comprehensive standard health benefits plan established by the Board; and

ii. Shall be filed for approval with the Commissioner and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(b) A carrier, association, multiple employer arrangement or out-of-State trust shall not renew or continue a health benefits plan that is neither a standard health benefits plan nor a non-standard health benefits plan.

11:21-3A.4 New issuance of non-standard health benefits plans

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall not issue a non-standard health benefits plan unless the non-standard health benefit plan:

1. Complies with the provisions of N.J.S.A. 17B:27A-18, 17B:27A-19b, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27;

2. Complies with all applicable rating and loss ratio requirements, and complies with all regulations adopted by the Commissioner pursuant to P.L. 1995, c.340, § 7; and

3. If issued by a carrier through an out-of-State trust:

i. Offers benefits that are at least equal to the actuarial value and benefits coverage of the least comprehensive standard health benefits plan established by the Board; and

ii. Is filed for approval with the Commissioner and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(b) An association, multiple employer arrangement or out-of-State trust may offer and issue a non-standard health benefits plan provided that the association, multiple employer arrangement, or out-of-State trust:

1. Shall offer and issue a non-standard health benefits plan to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust;

2. Shall offer or issue coverage only to a small employer that is or becomes a member of that association, multiple employer arrangement or out-of-State trust;

3. Shall not use actual or expected health status in determining its membership; and

4. Shall make available to its small employer members at least one of the standard health benefits plans, as determined by the Commissioner, in addition to any health benefits plans permitted to be renewed or continued pursuant to this subsection.

(c) A carrier may, but is not required to, issue to a small employer a non-standard health benefits plan that had been issued to the small employer by another carrier, so long as the replacing carrier has filed the health benefits plan with the Commissioner for approval and the carrier has received approval from the Commissioner, or the filing is deemed approved.

(d) A carrier may, but is not required, to issue a non-standard health benefits plan to a small employer through an association, multiple employer arrangement or out-of-State trust if the non-standard health benefits plan had previously been issued to a small employer by another carrier through the same association, multiple employer arrangement or out-of-State trust, so long as the replacing carrier files the non-standard health benefits plan with the Commissioner for approval and the carrier has received approval from the Commissioner or the filing is deemed approved.

(e) A carrier, association, multiple employer arrangement or out-of-State trust shall not offer or issue a health benefits plan that is neither a standard health benefits plan nor a non-standard health benefits plan.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (d), deleted "After January 5, 1996," at the beginning.

11:21–3A.5 Mandatory offerings by carriers issuing non-standard plans

(a) A carrier offering a non-standard health benefits plan through any arrangement, including by or through an association, multiple employer arrangement or out-of-State trust, shall also offer the standard health benefits plans to any small employer.

(b) An association, multiple employer arrangement or out-of-State trust that offers a non-standard health benefits plan to its member's employees and dependents shall make available to its small employer members at least one of the standard health benefits plans, as determined by the Commissioner, in addition to the non-standard health benefits plan.

11:21–3A.6 Amendment of a non-standard health benefits plan

(a) Except as set forth in (b) below, a carrier may amend the benefits structure of a non-standard health benefits plan so long as:

1. The amendment does not reduce the actuarial value and the benefits coverage of the health benefits plan below that of the least comprehensive standard health benefits plan established by the Board; and

2. The amendment has been filed with the Commissioner for approval and the amendment has been approved or deemed approved.

(b) A carrier shall not modify the benefit structure of a non-standard health benefits plan in any way within six months of issuing the non-standard health benefits plan previously issued by another carrier directly to the small employer.

11:21–3A.7 Penalties

A carrier, association, multiple employer arrangement or out-of-State trust that violates any provision of this subchapter shall be subject to penalty and fines available under law.

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, F, V, and W subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference. Members shall not make any changes to the text of the standard policy forms, except as permitted consistent with the explanation of brackets set forth as Exhibit K.

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

(c) Members shall use the standard policy form for HMO–POS plan which is set forth in the Appendix to this chapter as Exhibit HH and II, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(d) In issuing standard optional benefit riders pursuant to N.J.A.C. 11:21–3.2(c), members shall use the standard rider form which is set forth in the Appendix to this chapter as Exhibit H.

(e) 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.

(f) Members shall use the standard small group health benefits certificate for Plan A which is set forth in the Appendix to this chapter as Exhibit V, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(g) Members shall use the standard small group health benefits certificate for Plans B, C, D and E which is set forth in the Appendix to this chapter as Exhibit W, subject to the "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(h) Members shall use the standard employee evidence of coverage for HMO Plan which is set forth in the Appendix to this chapter as Exhibit Y, subject to "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(i) Members shall use the standard employee evidence of coverage for the HMO POS plan which is set forth in the Appendix to this chapter as Exhibit II, subject to "Explanation of Brackets" set forth in Exhibit K of the Appendix, incorporated herein by reference.

(j) Members that wish to use the standard Prescription Drug Rider shall use the form set forth in the Appendix to this chapter as Exhibit H.

(k) All small group health benefits certificates and employee evidences of coverage issued to employees covered under small employer health benefits plans on and after

January 1, 1994, shall be issued in accordance with these rules.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).
Amended by R.1994 d.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted new (c); recodified former (c) through (g) as (d) through (h); in (d), inserted text "standard optional benefit"; added (i); and recodified former (h) through (j) as (j) through (*l*).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), rewrote the introductory paragraph, and deleted "in triplicate" following "review" in 1i; in (b), inserted a reference to Exhibit Y in the introductory paragraph; and in (c), inserted a reference to Exhibit II in the introductory paragraph.
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote the section.

11:21–4.2 Certification or filing of forms

(a) No carrier shall issue any health benefits plan certificate or evidence of coverage to a small employer or the employees of a small employer or use any application form, employer or employee certification, waiver or enrollment form or make any amendments thereto until the carrier has certified that its health benefits plans and forms are in compliance with the small employer health benefits plans and all provisions of N.J.A.C. 11:21–4 and 6.

1. A carrier shall submit completed Certification of Compliance forms, set forth in Parts 1, 2 and 6 of Exhibit BB of the Appendix to this chapter and incorporated herein by reference upon entering the small employer market, on or before 45 days of the date amendments to the standard policy forms are effective, and on or before March 1 of each year thereafter. The market entry filing and the filing upon amendments being made to the standard policy forms shall address the plans the carrier will be marketing and issuing. The March 1 filing shall address the plans the carrier issued or renewed at anytime during the prior calendar year.

2. A carrier shall submit completed Certification of Compliance forms to the Board, at the address set forth at N.J.A.C. 11:21–1.3.

3. Certification of Compliance forms shall be certified by a duly authorized officer of the carrier.

(b) Carriers that submit Certification of Compliance forms may issue and make effective small employer health benefits plans upon filing such forms with the Board and the Commissioner, and may continue to do so until such time as the filing is disapproved in writing by the Board (in consultation with the Commissioner), following an opportunity for a hearing held in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and any rules promulgated thereunder.

(c) All forms to be used by a hospital service corporation and another carrier in conjunction in order to offer the small employer health benefits plans pursuant to N.J.S.A. 17B:27A–19e shall be submitted simultaneously to the Board and the Commissioner, and shall not be used until approved by the Board in consultation with the Commissioner.

1. Forms shall be submitted as set forth in (a)2 above.

2. Carriers shall submit a certification of substantial compliance and a description of the differences between the combined forms and the forms promulgated by the Board. The certification of substantial compliance shall be certified by a duly authorized officer of each of the carriers.

3. The Board shall notify the small employer carriers in writing within 60 days of receipt by the Board and the Commissioner of a completed submission, whether the combined forms are approved.

4. The small employer carriers shall have a right of appeal if the Board, in consultation with the Commissioner, disapproves the combined forms, in accordance with procedures established by the Board in its Plan of Operation.

(d) If the SEH Board adopts changes to the standard policy forms, a hospital service corporation and the carrier or carriers writing in conjunction with the hospital service corporation that has received approval by the SEH Board to issue plans pursuant to N.J.S.A. 17B:27A–19e shall submit revised forms to the SEH Board for review and approval within 60 days of the Board's adoption of changes to the standard policy forms. The revised forms shall not be used until approved by the Board in consultation with the Commissioner. Approval of previously approved forms will be withdrawn as of 60 days following the date the Board adopts changes to the standard policy forms.

New Rule, R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, (a)2, and (c), amended submission requirements.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted a reference to Part 6 of Exhibit BB in 1, and rewrote 2; in (b), deleted "with copies submitted to the Commissioner as set forth in (a)2 above" at the end; in (e), deleted "or January 1, 1994, whichever is later" following "Commissioner"; in (g)1, deleted "in triplicate" following "submitted"; and added (h).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), rewrote 1; deleted former (b) through (d) and recodified former (e) as (b); deleted former (f) and recodified former (g) and (h) as (c) and (d).

11:21–4.3 Standards for review

(a) In determining whether to approve combined forms (of a hospital service corporation and another small employer carrier), a carrier shall consider in submitting in its certification of substantial compliance (with respect to combined forms), and the Board and Commissioner shall consider in their review whether:

1. The inclusion of words, terms and descriptions that are not contained in the Board's forms changes the meaning or effect of any material aspect of the small employer health benefits plans and other attendant Board forms;

2. The combined forms contain all provisions required by New Jersey law and the small employer health benefits plans forms which, if not the same as that required by law or in the small employer health benefits plans forms, is at least as favorable to the covered person;

3. The combined forms contain all coverages, coverage limits and exclusions set forth in the small employer health benefits plans forms; and

4. Easy comparison with the appropriate small employer health benefits plans forms by the consumer, the Board or the Commissioner is impeded.

(b) In addition to (a) above, the Board, in consultation with the Commissioner, may disapprove combined forms on the grounds that its provisions are unjust, unfair, inequitable, misleading, contrary to law or to the public policy of this State.

New Rule, R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), deleted former 4, recodified former 5 as 4, and deleted references to alternative methods of utilization review throughout; in (b), deleted "an alternative method of utilization review or" preceding "combined forms".

11:21-4.4 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board, through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix, incorporated herein by reference, subject to the following:

1. If expressly permitted by the Board, the Compliance and Variability Rider may be issued by Members to incorporate changes to the standard policy forms Plans A-E, HMO and HMO POS contracts, certificates, evidences of coverage, or standard riders promulgated by the Board. Nothing contained herein shall prevent a Member from issuing a standard policy form Plans A-E, HMO or HMO POS contract, certificate, evidence of coverage or standard rider which has incorporated Board promulgated changes.

(b) Notwithstanding the requirements of N.J.A.C. 11:21-4.1, members may make any changes to the standard policy forms, standard HMO and HMO POS contracts, certificates, and evidences of coverage for Plans A, B, C, D, E, HMO, and HMO POS and for the standard riders promulgated by the Board consistent with the variability as explained in Exhibit K to this Appendix through the use of the Compliance and Variability Rider as set forth as Exhibit DD of the Appendix.

(c) Members may use the Compliance and Variability Rider only as permitted by (a) and (b) above. In no event shall the Compliance and Variability Rider be used in lieu of optional benefit riders which riders are subject to filing requirements set forth in N.J.A.C. 11:21-3.2(d).

New Rule, R.1995 d.312, effective June 19, 1995.
See: 27 N.J.R. 439(a), 27 N.J.R. 2407(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted references to HMO POS contracts throughout.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a)1, added "If expressly permitted by the Board," at the beginning, and inserted references to Plans A through E throughout; and in (b), inserted a reference to Exhibit JJ.
Amended by R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b), deleted "and JJ" preceding "to this Appendix".

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. STANDARD EMPLOYER AND EMPLOYEE APPLICATION AND SMALL EMPLOYER CERTIFICATION FORMS

11:21-6.1 Standard application form

(a) All small employer carriers offering small employer health benefits plans with an effective date on or after January 1, 1994, shall use the standard application form approved by the Board and specified in Exhibit N of the Appendix to this chapter incorporated herein by reference.

(b) Small employer carriers shall require any small employer applying for a small employer health benefits plan to be issued by that small employer carrier to complete, as part of the application, the New Jersey Small Employer Certification form approved by the Board and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference.

11:21-6.2 Annual Small Employer Certification Form

Small employer carriers shall require each small employer covered by a small employer health benefits plan issued by the small employer carrier to that small employer to complete each year the New Jersey Small Employer Certification form approved by the Board and specified in Exhibit O of the Appendix to this chapter incorporated herein by reference. This form shall be sent to the small employer for completion no earlier than 150 days prior to the renewal of the small employer's health benefits plan.

Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Substituted "150" for "120" in the last sentence.

11:21-6.3 (Reserved)

Amended by R.1994 d.418, effective July 15, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Inserted reference to HMO POS plan.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (b), substituted a reference to Exhibit Q for a reference to Exhibit R in the first sentence; and in (c), substituted "as optional text in Exhibit Q" for "in Exhibit S" in the second sentence of the introductory paragraph, and deleted "Beginning on September 11, 1994," at the beginning of 1.
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Section was "Enrollment".

11:21-6.4 Waiver

Any eligible employee who declines coverage under the small employer health benefits plan shall complete the employee waiver form approved by the Board and specified in Exhibit T of the Appendix to this chapter incorporated herein by reference.

Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted the last sentence.

SUBCHAPTER 7. PROGRAM COMPLIANCE

11:21-7.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering, issuing and renewing all health benefits plans to any small employer, the small employer's eligible employees, and the dependents of those eligible employees.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted "on or after January 1, 1994" at the end of the section.

11:21-7.2 Definitions

All words and terms used in this subchapter shall have the meanings as set forth in the Act, N.J.A.C. 11:21-1.2 or as further defined below, unless the context clearly indicates otherwise.

"Affiliated company" means a person that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another person. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§1395 et seq.); Title XIX of the Federal Social Security Act (42 U.S.C. §§1396 et seq.), other than coverage consisting solely of benefits under section 1928 of Title XIX of the Federal Social Security Act (42 U.S.C. §1396s); Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§1397aa through 1397jj), chapter 55 of Title 10, United States Code (10 U.S.C. §§1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; and a health plan offered under chapter 89 of Title 5, United States Code (5 U.S.C. §§8901 et seq.); a public health plan as defined by Federal regulation; a health benefits plan under section 5(e) of the "Peace Corps Act" (22 U.S.C. §2504(e)); or coverage under any other type of plan as set forth by the Commissioner by regulation. Creditable coverage shall not include coverage consisting solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage, as specified in Federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan.

"Enrollment date" means, with respect to a person covered under a health benefits plan, the date of enrollment of the person in the health benefits plan or, if earlier, the first day of the waiting period for such enrollment. If an employee changes plans or if the employer transfers coverage to another carrier, the covered person's enrollment date does not change.

"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, but only if the plan sponsor or carrier required such a statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, termination of the employer's contribution toward coverage, death of a spouse, or divorce or legal separation; 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 small employer is employed by an employer which offers multiple health benefits plans and the small employer elects a different plan during an open enrollment period; the small employer had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; or if a court of competent jurisdiction has ordered coverage to be 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. An eligible employee and his or her dependent spouse, if any, will not be considered late enrollees because the eligible employee initially waived coverage under the health benefits plan for himself or herself and any then existing dependents provided the eligible employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the plan within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.

"Non-standard health benefits plan" means only a health benefits plan that was issued to cover one or more small employers by or through a carrier, association, multiple employer arrangement or out-of-State trust prior to January 1, 1994, and which was in effect on February 28, 1994.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for that coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information. Pregnancy is not a preexisting condition.

"Public health plan" means any plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "Health benefits plan" and "Standard health benefits plan"; and added "Qualifying previous coverage.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Amended "Late enrollee".
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
In definition "Creditable coverage", inserted reference to "Title XXI of the Social Security Act (State Children's Health Insurance Program) (42 U.S.C. §§1397aa through 1397jj)", and inserted "a public health plan"; in definition "Enrollment date", added the last sentence; and added definition "Public health plan".

11:21-7.3 Eligibility and issuance

(a) Except as may otherwise be provided in N.J.A.C. 11:21-3A with respect to nonstandard health benefits plans, a small employer carrier shall issue a health benefits plan to any small employer which requests it, pays the premiums therefor and meets the contribution and participation requirements, if any, of the small employer carrier. All health benefits plans shall provide coverage for all eligible employees and their dependents who elect to participate regardless of health status-related factors and without exclusionary riders.

1. A small employer carrier shall not refuse to issue coverage, or discriminate in the issuance of coverage, to a small employer based upon the geographical location of the employees of the small employer, except that:

i. The small employer carrier shall refuse to issue coverage to an employer if the majority of its eligible employees are not employed within the State of New Jersey; or

ii. An HMO carrier may refuse to issue coverage to an employer to cover an employee that does not live, work, or reside in the small employer carrier's service area.

2. Every small employer carrier except small employer carriers that are HMOs, shall, as a condition of transacting business in this State, actively offer to small employers the five standard health benefits plans, including all riders it has elected to write, except as such riders may be restricted to specific standard health benefits plans. Small employer carriers that are HMOs shall, as a condition of transacting business in this State, actively offer to small employers every standard health benefits plan it writes, including all riders it has elected to write, except as such riders may be restricted to specific standard health benefits plans.

3. A small employer carrier shall consider the number of all eligible employees of all affiliated companies of a small employer in determining whether an employer is a small employer and in determining participation levels.

4. At the time of application, the determination of whether an employer is a small employer shall be based upon the small employer's completed New Jersey Small Employer Certification form.

i. If an employer qualifies as a small employer in the immediately preceding calendar year, the employer shall be considered a small employer regardless of the status of the employer on the date of application or the effective date of coverage so long as it employs at least two employees on the first day of the plan year.

ii. If an employer did not qualify as a small employer in the immediately preceding calendar year, the employer shall not be considered a small employer, regardless of the status of the employer on the date of

application or the proposed effective date of coverage, if any.

iii. In the case of an employer that was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. An employer that was not in existence during the preceding calendar year must have at least two eligible employees when completing the employer certification and on the first day of the plan year to be considered a small employer.

(b) Except as otherwise provided in N.J.A.C. 11:21-3A with respect to the issuance of non-standard health benefits plans, a small employer carrier shall issue only standard health benefits plans to an association, trust or multiple employer arrangement to provide coverage to member small employers or to two or more eligible employees of a member small employer.

1. No carrier shall issue a health benefits plan to any association, trust or multiple employer arrangement which bases membership criteria of any small employer or employee of the small employer, in whole or in part, upon the health status or claims experience of the employer or employee.

2. Every small employer member of an association, trust or multiple employer arrangement shall be offered coverage under every health benefits plan issued to the association.

(c) In determining an employer's number of eligible employees, a small employer carrier shall consider in the calculation the number of independent contractors that the employer may include on its application for coverage to the extent that each independent contractor:

1. Is performing a service for the employer pursuant to a written contract for monetary or other legal consideration;

2. Is working exclusively for the employer;

3. Works 25 or more hours per week for the employer;

4. Works on other than a temporary or substitute basis; and

5. The independent contractor relationship has been established to serve a substantial business need of the employer and is not intended primarily to obtain insurance coverage.

(d) Employees who enroll within 30 days of first becoming eligible for coverage shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to their risk characteristics or that of their dependents, except that a small employer carrier may exclude coverage for preexisting conditions consistent with the provisions of N.J.A.C. 11:21-7.7. Employees who are late enrollees shall be accepted for coverage by the small employer carrier, but a small employer carrier may exclude coverage for preexisting conditions consistent with the provisions of N.J.A.C. 11:21-7.8. Small employer carriers shall not delay the effective date or eligibility date of a late enrollee until an "open enrollment" period.

(e) A small employer carrier may elect to provide coverage to a small employer's part-time employees (that is, working fewer than 25 hours per week), if the small employer covered part-time employees under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all part-time employees of all such small employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts.

2. Such covered employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(f) A small employer carrier may elect to provide coverage to a small employer's retired employees, if the small employer's retired employees were covered under a health benefits plan issued prior to January 1, 1994, when the carrier renews or reinstates the plan in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or when the carrier converts the small employer to a standard health benefits plan, provided that:

1. The small employer carrier shall offer to cover all retired employees of all such employers so renewing or reinstating such health benefits plans and/or converting to standard health benefits plans, and, in the latter case, shall do so without regard to the standard health benefits plan to which a small employer converts; and

2. Such covered retired employees shall not be considered in determining whether an employer is a small employer, nor for determining whether the small employer meets the requisite participation requirements.

(g) A small employer carrier may elect to provide coverage to retired employees and/or part-time employees of an employer that becomes a small employer subsequent to January 1, 1994, if the employer covered retired and/or part-time employees under a group health plan issued prior to January 1, 1994, under a health benefits plan renewed or reinstated by the carrier in accordance with P.L. 1994, c.11 as amended by P.L. 1995, c.340, or a standard health benefits

plan issued to the small employer by the carrier, subject to the requirements of (e)1 and 2 and (f)1 and 2 above.

(h) In the event that the previous health benefits plan of a small employer group was cancelled for nonpayment of premiums or fraud, a small employer carrier may require the small employer group to pay up to six months of premiums in advance of the issuance of a health benefits plan.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended (a); in (b), amended N.J.A.C. reference; and in (e), (f), and (g), substituted P.L. reference for N.J.A.C references.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), substituted a reference to health status-related factors for a reference to health in the introductory paragraph, substituted references to calendar years for references to calendar quarters throughout 5, added "so long as it employs at least two employees on the first day of the plan year" at the end of 5i, deleted ", except as set forth in (iii) below" at the end of 5ii, and rewrote 5iii; and in (d), added the second and third sentences.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote (a) and added (h).

11:21-7.4 Limitations on purchase by small employers of health benefits plans or riders with different actuarial value than existing plan

(a) A small employer who purchases a health benefits plan or rider pursuant to the Act shall not be permitted to purchase a health benefits plan or rider with a greater actuarial value until the first anniversary date of the small employer's existing health benefits plan.

(b) When a small employer replaces a health benefits plan or rider with a health benefits plan or rider of greater actuarial value, the small employer shall not be permitted to change the health benefits plan or rider to one of less actuarial value until the anniversary date of the small employer's health benefits plan.

(c) A small employer who has purchased a health benefits plan or rider pursuant to the Act may purchase a health benefits plan or rider of lesser actuarial value prior to the anniversary date of the existing health benefits plan or rider, provided that the existing health benefits plan or rider was purchased at least 12 months prior to the latest anniversary date of the health benefits plan or rider.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.5 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted "standard" "preceding health benefits plan" throughout. Section was "Carriers acting as administrators for small employers".
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted (d).

11:21-7.5 Participation requirements

(a) A small employer carrier shall require a minimum participation under the small employer's health benefits plan of 75 percent of eligible employees who are not serving under a waiting period as permitted under N.J.A.C. 11:21-7.8(c), except as set forth in (b) below. This participation requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers. A carrier shall count as covered under the small employer's health benefits plan, for the purpose of satisfying employee participation requirements, an eligible employee who:

1. Is covered as an employee or dependent under any fully insured health benefits plan offered by the small employer;

2. Is covered under Medicare;

3. Is covered under Medicaid or NJ FamilyCare;

4. Is covered under another group health benefits plan; or

5. Is covered under a spouse's health benefits plan.

(b) A small employer carrier may, upon approval by the Board, require a minimum participation of less than 75 percent provided that the small employer carrier:

1. Notifies the Board in writing of its minimum requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser participation requirements, in accordance with procedures established by the Board in its Plan of Operation.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Amended by R.1995 d.630, effective December 4, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3118(a), 27 N.J.R. 4895(a).
Recodified from 11:21-7.6 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended (a). Former section recodified to N.J.A.C. 11:21-7.4.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted "who are not serving under a waiting period as permitted under N.J.A.C. 11:21-7.8(c)," in the first sentence of the introductory paragraph, inserted "as an employee or dependent" in 1, and substituted a reference to creditable coverage for a reference to qualifying previous coverage at the end of 2.
Amended by R.2004 d.107, effective March 15, 2004.

See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), inserted "fully insured" preceding "health benefits" in 1, rewrote 2 and added 3 and 4.
Amended by R.2006 d.145, effective April 17, 2006 (operative June 1, 2006).
See: 37 N.J.R. 4869(a), 38 N.J.R. 1751(a).
Inserted new (a)3. and recodified previous (a)3. and (a)4. as (a)4. and (a)5.

11:21-7.6 Contribution requirements

(a) A small employer carrier shall not require a minimum small employer contribution of more than 10 percent of the annual cost of the small employer's health benefits plan. This contribution requirement shall be applied by the small employer carrier uniformly among all health benefits plans and all small employers.

(b) A small employer carrier may, upon approval of the Board, require a minimum contribution of less than 10 percent provided that the small employer carrier:

1. Notifies the Board in writing of its contribution requirement;

2. Explains why the lesser requirement is reasonable; and

3. Applies the requirement uniformly to all small employer health benefits plans and to all small employers.

(c) The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

(d) The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's lesser contribution requirements, in accordance with procedures established by the Board in its Plan of Operation.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.7 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.5.

11:21-7.7 Preexisting condition standards

(a) A health benefits plan shall not include a preexisting condition exclusion, except as provided in (b) or (c) below.

(b) A health benefits plan issued to a small employer with five or fewer eligible employees, as determined on the effective date of the plan and on each subsequent policy anniversary, may contain a preexisting condition exclusion. However, a preexisting condition exclusion shall not exclude coverage for a period of more than 180 days following the enrollment date, and shall relate to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of the enrollee and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date.

(c) A health benefits plan issued to a small employer may contain a preexisting condition exclusion that may apply to a late enrollee. However, a preexisting condition exclusion shall not exclude coverage for a period of more than 180 days following the enrollment date of coverage, and shall relate to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of the enrollee and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date of coverage. If 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition exclusion shall apply to any such enrollee.

(d) In determining whether a preexisting condition provision applies to an eligible employee or dependent, carriers shall credit the time that person was covered under previous creditable coverage if the creditable coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any waiting period under such plan. A carrier shall provide credit pursuant to this provision pursuant to one of the following methods:

1. A carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period; or

2. A carrier shall count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits specified in Federal regulation rather than the method provided in (d)1 above. This election shall be made on a uniform basis for all covered persons. Under this election, a carrier shall count a period of creditable coverage with respect to any class or category, of benefits if any level of benefits is covered within that class or category. A carrier which elects to provide credit pursuant to this provision shall comply with all Federal notice requirements.

(e) A health benefits plan shall not impose a preexisting condition exclusion for the following:

1. A newborn child who, as of the last date of the 30-day period beginning with the date of birth, is covered under creditable coverage;

2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of the adoption or placement for adoption; or

3. Pregnancy.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.8 and amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.6.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21-7.8 Effective date of coverage

(a) A small employer carrier, prior to issuing a health benefits plan, may require the following:

1. A completed small employer standard application form including the small employer certification form in accordance with N.J.A.C. 11:21-6.1(a) and (b);

2. Complete employee enrollment forms and waiver forms; and

3. An advance premium payment not to exceed one month's premium, except as provided in N.J.A.C. 11:21-7.5(d)2, which shall be refunded to the employer if the health benefits plan is not issued by the small employer carrier.

(b) A small employer carrier shall provide notice to the employer within 15 working days of receipt by the small employer carrier of the information set forth in (a) above whether the small employer carrier approves or disapproves the employer's application for the health benefits plan. If approved, the effective date of coverage under the health benefits plan shall be no later than the first day of the month following the date of notice of such approval by the small employer carrier unless the small employer has requested a later effective date which is agreed to by the small employer carrier.

(c) At the option and upon the request of the small employer, a waiting period may be applied by the small employer carrier with respect to employees when they first become eligible for coverage, not to exceed six months. Waiting periods may be applied to these employees by class of employee based upon conditions pertaining to employment.

(d) A small employer carrier may offer an automatic checking withdrawal option to small employer groups for the monthly or quarterly payment of premiums. In the event that a small employer carrier elects to offer an automatic checking withdrawal option, the carrier shall offer the same option to all small employer groups, regardless of the size of the group or the type of health benefits plan.

(e) A small employer carrier may require that its small employer groups make monthly or quarterly premium payments through an automatic checking withdrawal option. In the event that a small employer carrier elects to require that its small employer groups pay premiums through an automatic checking withdrawal option, the small employer carrier shall apply this requirement to every small employer group, regardless of the size of the group or the type of health benefits plan.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21–7.9 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.7.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a)2, substituted "forms and waiver forms" for the N.J.A.C. reference.

11:21–7.9 Price quotes; disclosures

(a) A small employer carrier shall provide a price quote to a small employer, directly or through an authorized third party, within 10 working days of receiving a request for a quote and such information as is reasonable and necessary to provide the quote. A small employer carrier shall notify a small employer, directly or through an authorized producer, within five working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

(b) Each small employer carrier shall make reasonable disclosure in price quotes provided to small employers of the provisions concerning the small employer carrier's right to change premiums and the criteria in the small employer carrier's rate filing which affect changes in premium rates.

Recodified from 11:21–7.10 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.8.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), substituted "third party" for "producer" following "authorized".

11:21–7.10 Tie-ins

A small employer carrier shall not require, as a condition to the offer or sale of a health benefits plan to a small employer, that the small employer purchase or qualify for any other insurance products or services.

Recodified from 11:21–7.11 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.9.

11:21–7.11 Guaranteed renewal

(a) All health benefits plans that are issued or renewed on or after January 1, 1994, must be guaranteed renewable at the option of the policy or contract holder or small employer, except that a carrier may discontinue a health benefits plan pursuant to (b) below or nonrenew a health benefits pursuant to (c) below.

(b) A carrier may discontinue a health benefits plan only if:

1. The policyholder, contract holder, or employer has failed to pay premiums or contributions in accordance with the terms of the health benefits plan or the carrier has not received timely premium payments; or

2. The policyholder, contract holder, or employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(c) A carrier may nonrenew a health benefits plan only if:

1. The number of employees covered under the health benefits plan is less than the number or percentage of employees required by participation requirements under the health benefits policy or contract;

2. The small employer fails to comply with a small employer carrier's employer contribution requirements;

3. The carrier files with the Commissioner to withdraw from the small employer market and meets the requirements of N.J.A.C. 11:21–16;

4. The small employer ceases its membership in an association or trust of employers where the health benefits plan was issued in connection with such membership;

5. The carrier receives approval to cease offering and renewing a particular type of a plan and meets the requirements of N.J.A.C. 11:21–13;

6. The SEH Board discontinues a particular standard health benefits plan or plan option; or

7. In the case of a health maintenance organization plan issued to a small employer:

i. An eligible person who no longer resides, lives, or works in the carrier's approved service area, but only if coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

ii. A small employer that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the carrier and the carrier would deny enrollment with respect to such plan pursuant to N.J.S.A. 17B:27A–26.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21–7.12 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Deleted (a)6, relating to coverage for less than two employees; recodified (a)7 and (a)8 as (a)6 and (a)7; and added (b). Former section recodified to N.J.A.C. 11:21–7.10.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21–7.12 Reporting requirements

(a) A small employer carrier shall file with the Board, quarterly no later than 45 days after the end of the fiscal quarter, the following information reported separately with respect to standard and non-standard health benefits plans:

1. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter, reported separately as to newly issued plans and renewals, and separately for stan-

dard health benefits plans A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

2. The total number of health benefits plans in force at the end of the quarter, and the total number of employees and dependents covered, reported separately for each standard health benefits plan A, B, C, D, E, plans A, B, C, D, and E sold through or in conjunction with a selective contracting arrangement, HMO, and HMO POS;

3. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter and were uninsured for at least the three months prior to issue.

(b) Quarterly reports shall be filed at the address listed in N.J.A.C. 11:21-1.3.

(c) An insurance company, health service corporation, hospital service corporation, or medical service corporation and affiliated health maintenance organization shall file separate reports.

Amended by R.1994 d.499, effective September 2, 1994.
See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).
Recodified from 11:21-7.13 and amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a)1, (b)1, and (b)2, inserted reference to plans sold through selective contracting and to HMO POS; in (a)2, substituted reference to geographic territory for reference to three digit zip code and amended N.J.A.C. reference; and added (d) and (e).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (b), deleted "Effective on the fiscal quarter ending on September 30, 1994," at the beginning; deleted a former (d); and recodified former (e) as (d).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Deleted (a); recodified former (b) through (d) as (a) through (c); in (b), substituted "Quarterly" for "Annual and quarterly".

11:21-7.13 Paying benefits

(a) In paying benefits for covered services under the terms of the small employer health benefits plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services, on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means a standard based on the Prevailing Healthcare Charges System profile for New Jersey or other state when services or supplies are provided in such state, incorporated herein by reference published and available from the Ingenix, Inc., 12125 Technology Drive, Eden Prairie, Minnesota 55344.

1. The maximum allowable charge shall be based on the 80th percentile of the profile.

2. Carriers shall use the profile effective as of July 1993, and shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

Recodified from 11:21-7.14 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21-7.12.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), rewrote the introductory paragraph.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), amended the address at the end of the introductory paragraph.

11:21-7.14 Permissible rate classification factors

(a) For health benefits plans issued or renewed on or after September 11, 1994, a carrier shall not differentiate premium rates charged to different small employers for the same health benefits plan except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25–29; 30–34; 35–39; 40–44; 45–49; 50–54; 55–59; 60–64; 65–69; 70 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first three digits of the U.S. Postal Service zip codes or the counties listed below. A carrier shall determine which territory applies to a small employer on the basis of the address of the small employer's principal place of business. The six territories are the following:

i. Territory A consists of zip codes 070–073 or Essex, Hudson and Union counties;

ii. Territory B consists of zip codes 074–076 or Bergen and Passaic counties;

iii. Territory C consists of zip codes 077–079 or Monmouth, Morris, Sussex and Warren counties;

iv. Territory D consists of zip codes 088–089 or Hunterdon, Middlesex and Somerset counties;

v. Territory E consists of zip codes 081, 085–086 or Burlington, Camden, and Mercer counties; and

vi. Territory F consists of zip codes 080, 082–084, and 087 or Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

(b) Notwithstanding (a) above, a carrier may differentiate premium rates charged to different small employers for the same standard health benefits plan, whether it be A, B, C, D, E, HMO, or HMO–POS, on the basis of family structure according to only the following four rating tiers:

1. Employee only;

2. Employee and spouse;

3. Employee and child(ren); and

4. Family.

New Rule, R.1994 d.418, effective July 15, 1994 (operative September 11, 1994).
See: 26 N.J.R. 2843(a), 26 N.J.R. 3442(b).
Recodified from 11:21–7.15 by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Former section recodified to N.J.A.C. 11:21–7.13.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b), inserted "or HMO-POS, " following "or HMO" in the introductory paragraph.

11:21–7.15 Employer waiting period

A small employer carrier shall not be required to modify the waiting period provision of a health benefits plan except as of an anniversary date of the plan, and upon the request of a small employer.

New Rule, R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

SUBCHAPTER 7A. LOSS RATIO REPORTS; DIVIDENDS AND CREDITS

11:21–7A.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of N.J.S.A. 17B:27A–19.3 and 25.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Substituted a reference to N.J.S.A. 17B:27A–19.3 and 25 for a reference to the Act.

11:21–7A.2 Definitions

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

"Closed nonstandard health benefits plan" means a closed nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

"Open nonstandard health benefits plan" means an open nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

"Preceding calendar year" means the calendar year immediately preceding the reporting year.

"Reporting year" means the year in which the loss ratio report is required to be filed with the Department.

"Small employer purchasing alliance," "purchasing alliance" or "alliance" means a small employer purchasing alliance as established pursuant to N.J.S.A. 17B:27A–25.3.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Inserted "Closed nonstandard benefits plan" and "Open nonstandard health benefits plan"; and deleted "Total employee months exposed".
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Added "Small employer purchasing alliance".

11:21–7A.3 Filing of loss ratio reports

(a) Each carrier having the five standard health benefits plan policy forms, open or closed nonstandard health benefits plan policy forms or HMO plans in force at any time during the preceding calendar year shall file with the Department an annual loss ratio report on the form appearing as Exhibit GG in the Appendix to this chapter, incorporated herein by reference. The annual loss ratio report, beginning with 1997 data reported in 1998, shall:

1. Aggregate standard health benefit plans, other than alliance plans, including all standard and nonstandard riders and endorsements thereto;

2. Aggregate open nonstandard health benefits plans, including all riders and endorsements thereto;

3. Aggregate closed nonstandard health benefits plans including all riders and endorsements thereto; and

4. Aggregate alliance health benefits plans, including all riders and endorsements thereto.

(b) The loss ratio report shall be completed and filed with the Department on or before August 1 of the reporting year for the preceding calendar year.

(c) Loss ratio reports submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Loss Ratio Report Filings
Life and Health Division
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote (a); and in (b), deleted exception at the end of the sentence.
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
In (a), inserted "other than alliance plans" preceding "including", "and endorsements" preceding "thereto" in 1 and added 4.

11:21–7A.4 Contents of the loss ratio report

(a) A loss ratio report filed pursuant to N.J.A.C. 11:21–7A.3 shall include the following information:

1. The reporting carrier's name and address;

2. The carrier's earned premiums, before dividends or credits applicable to prior years, and claims for the preceding calendar year, calculated pursuant to the instructions of Exhibit GG;

3. The carrier's loss ratio determined by dividing the claims by the premiums;

4. The carrier's calculation of the dividends and credits to be issued pursuant to N.J.S.A. 17B:27A-25g(2). (A credit is a dividend paid in the form of a reduction in a current premium due, as distinguished from dividends paid in cash.);

5. An explanation of the carrier's plan to issue dividends and credits;

6. An explanation of the carrier's plan to distribute a dividend in the event of cancellation or termination by a policyholder;

7. Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-25g(2), N.J.A.C. 11:21-7A and instructions; and

8. Such other information as the Department may request.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
In (a)2, substituted a reference to dividends for a reference to refunds, and added ", calculated pursuant to the instructions of Exhibit GG" at the end.

11:21-7A.5 Dividend or credit plan

(a) If the preceding calendar year loss ratio for any of the classifications listed in N.J.A.C. 11:21-7A.3(a) is less than 75 percent, the carrier shall include within the loss ratio report a plan to be approved by the Department for the distribution of all dividends and credits against future premiums for all policyholders with that classification in the preceding calendar year in an amount sufficient to assure that the claims in the preceding calendar year plus the amount of the dividends and credits shall equal 75 percent of the premiums for that classification in the preceding calendar year.

1. Carriers that issue health benefits plans through out-of-State trusts, associations or other multiple employer arrangements shall specify in the plan for distribution of dividends and credits that dividends and credits for such health benefits plans shall be paid or credited, as applicable, to the small employers covered under the health benefits plans, not the trust, association or other multiple employer arrangement.

2. Carriers that issue health benefits plans to small employers that are members of purchasing alliances shall specify in the plan for distribution of dividends and credits that dividends and credits for such health benefits plans shall be paid or credited, as applicable, to the small employers covered under the health benefits plans, not the trust, association or other multiple employer arrangement.

(b) The experience for all non-alliance standard health benefits plans shall be combined for dividend purposes.

(c) The experience for all alliance health benefits plans shall be combined for dividend purposes. The experience for alliance health benefits plans shall not be combined with the experience for non-alliance standard health benefits plans, or the experience of open or closed non-standard health benefits plans, for dividend purposes.

(d) The experience for all open nonstandard health benefits plans shall be combined for dividend purposes. Open nonstandard health benefits plans shall not be combined with any standard health benefits plans or closed nonstandard health benefits plans.

(e) The experience for all closed nonstandard health benefits plans shall be combined for dividend purposes. Closed nonstandard health benefits plans shall not be combined with any standard health benefits plans or open nonstandard health benefits plan.

(f) The dividends or credits shall be issued to each small employer who was covered for any period in the preceding calendar year.

(g) The dividend or credit amount per policyholder shall be determined by multiplying the premium for each policyholder by the percentage calculated by dividing the total dividend or credit by the total premium or on the basis of a practical and equitable alternate methodology filed by the carrier in accordance with (a) above.

(h) All dividends and credits shall be distributed by December 31 of the reporting year.

Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote (a) through (c); inserted a new (d); recodified former (d) through (f) as (e) through (g); in (e), substituted a reference to small employers for a reference to policyholders; in (f), substituted a reference to dividends and credits for a reference to refunds; and rewrote (g).
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
In (a), added 2; inserted a new (c) and recodified former (c) through (g) as (d) through (h).

SUBCHAPTER 8. CARRIER CERTIFICATION OF NON-MEMBER STATUS

11:21-8.1 Purpose and scope

(a) The purpose of this subchapter is to establish which carriers are not members of the SEH Program and how those carriers may be certified as non-members.

(b) This subchapter applies to any carrier which files Annual Statements with the Department evidencing premium earned on group health insurance.

Amended by R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to "other entities"; and in (b), deleted reference to accident insurance.

11:21–8.2 Definitions

Words and terms used in this subchapter shall have the meanings set forth in the Act or N.J.A.C. 11:21–1.2, unless the context indicates otherwise.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Group health benefits plan" and "Small employer".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21–8.3 Non-member status

(a) A carrier shall be a non-member of the SEH Program for the calendar year for which it submits a completed request for non-member certification unless the non-member certification is disapproved in writing by the Board. A carrier shall use the "Carrier Request for Non-Member Certification in the New Jersey Small Employer Health Benefits Program" form provided as Exhibit KK of these rules.

(b) A request for non-member certification shall state that:

1. The carrier neither issued nor had in force a group health benefits plan covering New Jersey small employers during the calendar year for which certification is submitted;

2. Other reasons which under law permit a carrier or entity to be certified a non-member.

Amended by R.1994 d.583, effective October 27, 1994.
See: 26 N.J.R. 4308(a), 26 N.J.R. 4629(a), 27 N.J.R. 1618(c).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), substituted "shall" for "may" following "carrier" in the second sentence.

11:21–8.4 Non-member certification requests

(a) To be considered a non-member in any calendar year, a carrier or entity shall file with the Board a completed request for non-member certification no later than March 1 of the following calendar year. Such request shall be sent to the SEH Program Administrator or Executive Director as specified at N.J.A.C. 11:21–1.3.

(b) All requests for non-member certification shall contain the statements required in N.J.A.C. 11:21–8.3 and be certified by a duly authorized officer of the carrier.

(c) A copy of such request also shall be filed by the carrier or other entity with the Commissioner as follows:

Attn: SEH Annual Certification of Non-Member Status
Life/Health Actuarial Services
New Jersey Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625–0325

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), deleted reference to non-members for calendar year 1993; and in (b), inserted reference to statements required by N.J.A.C. 11:21–8.3.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted a reference to the Executive Director in the second sentence.

11:21–8.5 Decisions on filings by the Board

The Board shall, if it determines that a carrier's non-member certification is incomplete, incorrect, or not in substantial compliance with this subchapter or other law, deny a request for non-member certification in writing, stating the reasons for the determination, after review of a carrier's filing. A copy of such decision shall be sent to the carrier and to the Commissioner.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Substantially amended section.

11:21–8.6 Review

A carrier which has been denied non-member certification may contest that determination by filing an appeal with the Board pursuant to procedures set forth in N.J.A.C. 11:21–2.17.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (c), substituted a reference to 45 days for a reference to 30 days in the first sentence.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote the section.

SUBCHAPTER 9. INFORMATIONAL RATE FILING REQUIREMENTS PURSUANT TO THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM

11:21–9.1 Purpose and scope

(a) The purpose of this subchapter is to establish informational rate filing requirements and procedures applicable to health benefits plans, including riders or endorsements, issued, renewed, reinstated or continued pursuant to N.J.S.A. 17B:27A–17 et seq.

(b) This subchapter applies to all carriers issuing, renewing, reinstating or continuing health benefits plans to small employers pursuant to N.J.S.A. 17B:27A–17 et seq.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Substituted references to N.J.S.A. 17B:27A-17 et seq. for references to the Act throughout.

11:21-9.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A-17 or N.J.A.C. 11:21-1.2 unless defined below or the context clearly indicates otherwise.

"Classification factor" means a factor used to vary rates based upon characteristics of the employee, employer or policyholder.

"Closed nonstandard health benefits plan" means a closed nonstandard health benefits plan as defined at N.J.A.C. 11:21-11.2.

"Effective date" means the date on which coverage begins for the policyholder.

"Health benefits plan" means any standard health benefits plan or nonstandard health benefits plan including any rider or endorsement thereto.

"Nonstandard health benefits plan" means a health benefits plan policy or contract form under which policies or contracts were issued on or before December 31, 1993 to small employers or to one or more employees of a small employer by virtue of the employment arrangement, or a policy or contract form under which policies or contracts were issued on or before December 31, 1993 to an association, out-of-State trust or multiple employer arrangement and offered to a small employer or to one or more employees of a small employer.

"Nonstandard rider" means a rider or endorsement developed by a carrier to be offered with one or more of the standard health benefits plans.

"Open nonstandard health benefits plan" means an open nonstandard health benefits plan as defined at N.J.A.C. 11:21–11.2.

"Plan" means a policy or contract form under which policies, contracts or certificates are issued evidencing benefits for expenses incurred or coverage of services rendered when referring to a type of health benefits plan.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board subject to the review and approval of the Commissioner.

"Standard rider" means a rider or endorsement promulgated by the SEH Board to be offered with one or more of the standard health benefits plans.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Inserted "Closed nonstandard health benefits plan" and "Open nonstandard health benefits plan"; and rewrote "Nonstandard health benefits plans".
Amended by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Added "Effective date".

11:21–9.3 Informational rate filing requirements for small employer health benefits plans issued or renewed after December 31, 1993

(a) All carriers issuing policies, contracts or certificates under health benefit plans to small employers, including any standard or nonstandard rider option, prior to issuing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the following data:

1. A plan schedule for each of the standard health benefits plans and nonstandard health benefits plans offered, outlining:

i. The benefit options available;

ii. The delivery system(s) for each plan;

iii. The in-network and out-of-network coinsurance percentages and/or copays for selective contracting arrangements or HMO point-of-service arrangements;

iv. The benefit differential for each nonstandard rider offered, separately specifying benefit increases and benefit decreases;

v. The basic premium rate or rating factors applicable for each option including the difference when Medicare is primary or secondary, based on actual employee or spouse Medicare coverage status. Reduced premium rates or rating factors must be provided when Medicare is primary for an employee eligible for Medicare by reason of age; and

vi. The coverage period, if any, for which the rates for a group are guaranteed;

2. A rate manual containing:

i. The numerical value of the classification factors utilized in the calculation of a group's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of the covered persons in accordance with N.J.A.C. 11:21–7.14;

ii. A written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates set forth pursuant to (a)1v above into the rates charged to a small employer group;

iii. A detailed example calculation, in the proposal format used by the carrier, for any one plan including a rider or POS option, showing all of the steps to develop premiums for a small group and demonstrating the adjustment, if any, to achieve the required 200 percent maximum ratio between the premiums for the highest rated group and the lowest rated group in the State; and

iv. A specification of the rule, which must be invariable, stating if the issue rate is based on the issue enrollment or the proposal rate.

3. A detailed actuarial memorandum setting forth the assumptions and methods used in the development of the rate, which shall include:

i. Recent claim cost experience, a description of the source of the claim costs and the time period for which the claim costs were calculated;

ii. The assumptions used in developing the anticipated loss experience and the basic premium rates specified in (a)1v above, and the anticipated distribu-

tion of business by rating classification described in (a)2 above;

iii. The assumptions underlying the reduced premium rates or rating factors where Medicare is primary for the employee or spouse based on the actual Medicare coverage status of the employee or spouse;

iv. A statement whether or not the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A-25g(2). If such dividends are payable, the carrier shall also submit the following:

(1) The detailed assumptions and practices for determining and distributing such dividends; and

(2) A demonstration that such dividends are not in violation of 3iv(4), 3iv(5) or 3iv(6) below, as appropriate;

v. A summary of the overall change in rate levels, including:

(1) The average percentage change, for each standard and nonstandard plan, between the rates contained in the rate filing and the rates that were in effect one year prior to the effective date of the rate filing; and

(2) The average percentage change, for each standard and nonstandard plan, between the rates contained in the rate filing and the rates contained in the immediately prior rate filing;

vi. A certification signed by a member of the American Academy of Actuaries attesting as follows:

(1) The filing is accurate and complete and complies with the provisions of this subchapter;

(2) The issue period for which the filed rates are applicable, which period shall not exceed 12 months;

(3) The anticipated incurred loss ratio for each plan, which shall not be less than 75 percent of the premium therefor;

(4) For rates to be charged for policies, contracts or certificates issued or renewed on or after January 1, 1996, that the rating methodology will not provide rates (for an individual and for each family status) for the highest rated group in this State which are greater than 200 percent of rates (for an individual and for each family status) produced for the lowest rated group in this State for each plan and option;

(5) That rates to be charged to any group do not vary based on any classification factor other than those permitted in (a)2i above; and

(6) Whether the rates for the Open Nonstandard and Closed Nonstandard plans are on the same or a different basis as the rates for the Standard plans and, if different, the average percentage relationship to the Standard plan basis; and

vii. A certification that the actuarial memorandum contains confidential and proprietary information, if it is the actuary's belief that it does.

(b) All carriers issuing or renewing policies, contracts or certificates under a standard health benefits plan (including any standard or nonstandard rider option after September 11, 1994), an open nonstandard health benefits plan or a closed nonstandard health benefits plan, prior to issuing or renewing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the data set forth in (a) above.

1. Carriers that issued or renewed open nonstandard health benefits plans or closed nonstandard health benefits plans prior to the effective date of this amendment shall have until 90 days following the effective date of this amendment within which to come into compliance with this subchapter.

(c) Any carrier which seeks to change its rates for its health benefits plans shall, prior to the effective date of the revised rates, submit to the Commissioner an informational filing which shall include all of the data set forth in (a) above.

(d) In addition to meeting the requirements of (a) through (c) above, an informational rate filing shall not be considered complete unless the plan schedule and rate manual meet the following format requirements:

1. Each page shall contain the name of the carrier for which the filing is made;

2. Each page shall be distinctively numbered;

3. If future filings may be made by way of replacement pages only, then each page shall be dated clearly and distinctively; and

4. In all instances, there shall be a table of contents which shall include the date of the most recent filing, and shall include the date(s) of the respective pages when filings are made by way of replacement page.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote the section.
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
In (a)3iv(5), substituted "(a)2i" for "(a)2ii".
Amended by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Rewrote the section.

11:21–9.4 Purchasing alliances

(a) All carriers providing discounts to small employer purchasing alliances shall file an informational rate filing with the Commissioner prior to the date of providing such discounts, which shall include the following data:

1. A statement that the discount is based on reductions in anticipated expenses and profit margins and not on favorable claims experience;

2. Information regarding the discounts, including:

i. The small employer rate filings ("reference filing") pursuant to N.J.A.C. 11:21–9.3 to which the discounts apply;

ii. Eligibility requirements that a small employer group must satisfy, including participation requirements or cost-sharing requirements;

iii. The amount of the discounts expressed as a percentage of the non-alliance premium for the same coverage and small employer group. If the same discount is not offered to all purchasing alliances, the criteria for the variation in the discount, which shall not include any of the factors set forth at N.J.A.C. 11:21–21.4(a);

iv. The contract issue or renewal period to which the discounts apply, the time period for which the discount is guaranteed, and any conditions for maintaining the discount; and

v. A statement that the same discount is available to all members of the purchasing alliance;

3. Information regarding the application of the discount to a particular group, including:

i. A written description in plain language of the method by which the discounted rate is obtained from the reference rate; and

ii. A detailed example calculation, in the proposal format used by the carrier, of the application of the discount to the example calculation found in the reference filing, showing all the steps necessary to develop the discounted premium from the undiscounted premium, and demonstrating the adjustment, if any, to achieve the required 200 percent maximum ratio between the premiums for the highest rated group and the lowest rated group in the State;

4. An actuarial memorandum setting forth the assumptions used in the development of the discount, which shall include:

i. The anticipated claim cost for the purchasing alliances;

ii. A demonstration that the discount is based on the anticipated expenses (including marketing and claims administration expenses) and profit margins, identifying those differences from the anticipated expenses and profit margins in the reference filing that are the only bases for the purchasing alliance discount;

iii. A statement whether or not the policyholder shall or may receive policyholder dividends, other than the dividends required by N.J.S.A. 17B:27A–25(g)(2). If such dividends are payable, the carrier shall also submit the following:

(1) The detailed assumptions and practices for determining and distributing such dividends; and

(2) A demonstration that such dividends are not in violation of 4iv(4), 4iv(5) or 4iv(6) below, as appropriate; and

iv. A certification signed by a member of the American Academy of Actuaries attesting to the following:

(1) That the filing is accurate and complete, and complies with the provisions of this subchapter;

(2) The issue period for which the discount is applicable;

(3) The anticipated incurred loss ratio for each plan offered to purchasing alliances, which shall not be less than 75 percent of the premium;

(4) That the rating methodology, taking into account both discounted and undiscounted rates, shall not provide rates for the highest group in the State that are greater than 200 percent of the rates (for an individual and each family status) produced for the lowest rated group in this State for each plan and option;

(5) That the rates to be charged to any group do not vary based on a classification factor other than those permitted in N.J.A.C. 11:21–9.3(a)2i;

(6) That discounted rates do not result in rates that vary between groups based upon a health status-related factor; and

(7) That the anticipated incurred loss ratio in (a)4iv(3) above exceeds the anticipated incurred loss ratio for the reference filing by an amount that reflects the expense and profit savings attributed to the purchasing alliance.

(b) A single filing shall be made, even if multiple purchasing alliances are covered. The addition of purchasing alliances or other changes shall require submission of an amendment or modification to the rate filing within 30 days of such change.

New Rule, R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Former N.J.A.C. 11:21–9.4, Informational filing procedures, recodified to N.J.A.C. 11:21–9.5.

11:21-9.5 Informational filing procedures

(a) Informational filings submitted pursuant to this subchapter shall be sent to the Department at the following address:

Attention: SEH Informational Rate Filings
Life and Health Division
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

(b) If the Commissioner determines that an informational filing submitted pursuant to this subchapter is incomplete, the Commissioner shall provide written notice within 60 days to the carrier specifying those portions of the filing which are deficient and the information required to be submitted by the carrier. The notice shall specify whether or not the informational filing is deemed to be in substantial compliance with the requirements of N.J.A.C. 11:21-9.3. If the Commissioner takes no action with respect to the informational filing within 60 days of the date of submission thereof, the information filing shall be deemed complete.

(c) If the informational filing is incomplete but in substantial compliance with the requirements of N.J.A.C. 11:21-9.3, the carrier shall, within 30 days of receipt of written notice in (b) above, provide the Commissioner with the information required to complete the filing. Failure on the part of the carrier to comply with the provisions of this subsection may result in the imposition of a penalty pursuant to N.J.A.C. 11:21-9.6.

(d) If the informational filing is incomplete and not in substantial compliance with the requirements of N.J.A.C. 11:21-9.3, the Commissioner shall provide written notice to the carrier specifying the portions of the filing which are deficient and the information required to be submitted by the carrier. Upon receipt of notice from the Commissioner that the filing for any health benefits plan is not in substantial compliance, no contract, policy or certificate shall be entered into or renewed using the submitted rates until the Commissioner has determined that the informational filing is in substantial compliance or complete, and has provided written notice of that fact to the carrier. If the Commissioner takes no action within 30 days of the carrier's submission of information in an effort to render the filing in substantial compliance, the filing shall be deemed to be in substantial compliance.

(e) Any carrier aggrieved by a determination of the Commissioner pursuant to (b), (c) or (d) above may request a hearing on the Commissioner's determination, within 20 days of the receipt of notice of such determination, as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the notice involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the reason(s) the carrier is aggrieved by the Commissioner's determination.

2. The hearing shall be conducted pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

(f) The Commissioner may disapprove a purchasing alliance rate reduction if it results in rates that are excessive, inadequate or unfairly discriminatory.

1. Rates will be considered excessive if they are projected to give rise to a loss ratio that is less than the loss ratio for the reference rate filing, increased by an amount that reflects the savings giving rise to the discount.

2. Rates will be considered inadequate if they result in a subsidization of the alliance business by the non-alliance business.

3. Rates will be considered unfairly discriminatory if they are based on a health status-related factor of the group or any individual eligible for coverage in the group.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
In (b), increased periods for providing written notice and taking action from 30 to 60 days.
Recodified from N.J.A.C. 11:21-9.4 and amended by R.2002 d. 342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Added (f). Former N.J.A.C. 11:21-9.5, Public disclosure of filed information, recodified to N.J.A.C. 11:21-9.6.

11:21-9.6 Errors in rate quotations and rate calculation

(a) Any carrier that quotes, bills or collects a premium to or from a small employer that is less than the rate shown in the carrier's informational SEH rate filing in effect at the time the premium is billed or collected shall:

1. Provide written notice to the small employer of the error as soon as possible but no later than 30 days after discovery of the error;

2. Be prohibited from charging, collecting, offsetting or otherwise recouping the amount of the undercharges; and

3. Continue to charge the erroneous rate for a period of at least 60 days from the date the written notice of the error is received by the small employer.

(b) Any carrier that quotes, bills or collects a premium to or from a small employer that is more than the rate shown in the carrier's informational SEH rate filing in effect at the time the premium is billed or collected shall:

1. Immediately cease charging the incorrect rate and charge the correct rate;

2. Provide written notice to the small employer of the error as soon as possible but no later than 30 days after discovery of the error; and

3. Send the small employer a refund or post a premium credit within 30 days after discovery of the error for the full amount of all overcharges.

(c) If more than 50 small employer groups were undercharged or overcharged as a result of the error, a carrier shall provide the Department at the address listed at N.J.A.C. 11:21–9.4(a) with a certification describing the nature and scope of the error, including a list of all small employers affected and a sample copy of the notice to all small employers.

(d) The requirements of this section shall not apply to any deviation in rates from the filed rates that is less than one-quarter of one percent (.25 percent) or that arises from a rounding error of less than $1.00.

New Rule, R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Former N.J.A.C. 11:21–9.6, Public disclosure of filed information, recodified to N.J.A.C. 11:21–9.7.

11:21–9.7 Public disclosure of filed information

(a) All data or information filed with the Department pursuant to N.J.A.C. 11:21–9.3(a) are public records and may be disclosed in accordance with N.J.S.A. 47:1A–1 et seq., except that actuarial memoranda which contain confidential and proprietary information pursuant to N.J.A.C. 11:21–9.3(a)3 shall not be disclosed by the Department to any person other than employees and representatives of the Department.

(b) A carrier shall separately identify in all informational rate filings the confidential actuarial information from all other information required by this regulation. If not so identified, all information shall be considered public information and subject to disclosure.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Recodified from N.J.A.C. 11:21–9.5 by R.2002 d. 342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Former N.J.A.C. 11:21–9.6, Penalties, recodified to N.J.A.C. 11:21–9.7.
Recodified from N.J.A.C. 11:21–9.6 by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Former N.J.A.C. 11:21–9.7, Penalties, recodified to N.J.A.C. 11:21–9.8.

11:21–9.8 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of fines or other penalties provided by N.J.S.A. 17B:27A–43.

Recodified from N.J.A.C. 11:21–9.6 by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Recodified from N.J.A.C. 11:21–9.7 and amended by R.2003 d.126, effective March 17, 2003.
See: 34 N.J.R. 826(a), 35 N.J.R. 1430(b).
Substituted "N.J.S.A. 17B:27A–43" for "law, including suspension or revocation of a carrier's authority to do business in the State of New Jersey".

SUBCHAPTER 10. THE MARKET SHARE REPORT

11:21–10.1 Scope and applicability

(a) This subchapter sets forth annual reporting requirements of market share data for the assessment of operational and administrative expenses of the SEH Program.

(b) This subchapter shall apply to all carriers that are, or become, members of the SEH Program for any portion of a calendar year for which reports under this subchapter are required to be filed, whether or not the carrier is a member on the report filing due date.

11:21–10.2 Definitions

Words and terms used in this subchapter shall have the meanings as set forth in the Act or the chapter, unless the context clearly indicates otherwise.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Amended "Small employer".
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote the section.

11:21–10.3 Filing of the Market Share Report

(a) Every member of the SEH Program shall file the Market Share Report set forth as Exhibit CC in the Appendix to this chapter, incorporated herein by reference, on or before March 1. Every member shall complete Parts A, B, C and D of the Market Share Report.

1. Affiliated carriers shall submit a combined Market Share Report, except as (a)2 below implies. The combined Market Share Report shall be submitted under the name of one of the affiliated carriers' members.

2. Any insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in the State, and any health maintenance organization located in the State that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall submit separate Market Share Reports.

(b) Certified Market Share Reports shall be submitted by mail or facsimile to the SEH Program Administrator or Executive Director, as set forth at N.J.A.C. 11:21-2.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), deleted "April 15, 1994 and annually thereafter no later than" following "before" in the first sentence of the introductory paragraph; and in (b), inserted a reference to the Executive Director.

11:21-10.4 Net earned premium

(a) Every member's net earned premium for the preceding calendar year ending December 31 shall be set forth in Part C of the Market Share Report.

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers, less any refunds paid by the carrier during that calendar year as a result of the application of the minimum loss ratio requirement.

2. Net earned premium reported in Part C of the Market Share Report shall be based upon, if not the same as, the data set forth in the member's annual NAIC statement blank, adjusted to meet the definition of group health benefits plan and exclude refunds as described in (a)1 above, as necessary.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Rewrote (a)2.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
Rewrote the section.

11:21-10.5 Certification

All reports shall be certified as accurate, complete and conforming with the requirements of this subchapter by the Chief Financial Officer or other duly authorized officer of the member.

11:21-10.6 Failure to comply

Failure to comply with the reporting provisions of this subchapter shall result in the Board determining that the premium set forth in the member's most recent Annual Statement filed with the Department is the premium based upon which that member's market share allocation of assessments shall be calculated by the Board.

SUBCHAPTER 11. NONSTANDARD HEALTH BENEFITS PLANS (FILINGS WITH THE COMMISSIONER): REQUIREMENTS FOR MAINTAINING NONSTANDARD PLANS

11:21-11.1 Purpose and scope

(a) This subchapter applies to nonstandard health benefits plans which were in effect on December 31, 1993 and have been renewed, continued or reinstated and filed with the Commissioner for informational purposes in accordance with N.J.S.A. 17B:27A-19j(6)(a) on or before January 31, 1994 which may continue to be renewed, amended and moved to another carrier by a small employer or an association, out-of-State trust and multiple employer arrangement subject to the approval of the Commissioner, but which are not subject to N.J.S.A. 17B:27A-19b, and the rating of which shall be segregated from the rating of all other health benefits plans.

(b) This subchapter defines the procedures for filing and standards for approval of nonstandard health benefits plans which were in effect on December 31, 1993 and have been renewed, continued or reinstated and filed with the Commissioner for informational purposes in accordance with N.J.S.A. 17B:27A-19j(6)(a) on or before January 31, 1994 which the carrier, association, out-of-State trust or other multiple employer arrangement shall continue to issue, and renew, and may amend and which may be moved from one carrier to another by a small employer or an association, out-of-State trust and multiple employer arrangement subject to the approval of the Commissioner.

(c) This subchapter establishes the procedures for making a complete filing of nonstandard health benefits plans with the Commissioner for renewal, amendment or movement to another carrier, and the standards for review of the filings submitted.

(d) This subchapter sets forth standards for renewal of a nonstandard health benefits plan, and standards for determining what constitutes a request for renewal by a small employer.

Amended by R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).
Substantially amended section.

11:21-11.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as set forth at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.2, unless defined below or the context indicates otherwise.

"Benefits coverage" means the services and supplies covered by a health benefits plan and certain general provisions, definitions and covered charges with special limitations (as specified in the Checklist and Certification set forth in Part 5 of Exhibit BB of the Appendix to N.J.A.C. 11:21, incorporated herein as part of this subchapter) governing the health benefits plan.

(d) The Commissioner shall review the notice of withdrawal to determine whether it complies with (c) above and whether sufficient notice will be provided to policyholders. The Commissioner shall notify, in writing, the small employer carrier of any deficiencies and the requirements which are necessary to bring it into compliance with N.J.S.A. 17B:27A–23 and this subchapter.

(e) Any small employer carrier which seeks to withdraw from the small employer market shall, not later than two months following the date of notification to the Commissioner, nor less than six months in advance of the nonrenewal on the anniversary date of the policy or contract, mail notices to every small employer insured by the carrier, with copies for each covered person, informing the small employer and all covered persons that the policy or contract will be nonrenewed on the anniversary date. This initial notice to each small employer shall be sent by certified mail and shall include the following information:

1. The date upon which the policy or contract shall be nonrenewed;

2. That the policy or contract is being nonrenewed under the authority of N.J.S.A. 17B:27A–23e and this subchapter;

3. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the withdrawal;

4. A statement that the small employer may contact its broker for additional information regarding the withdrawal;

5. A notice that a list of active small employer carriers and information about small employer health benefits coverage may be obtained by writing to the New Jersey Small Employer Health Benefits Coverage Program Board, PO Box 325, Trenton, NJ 08625–0325 or by calling 1–800–263–5912, and requesting a copy of the "Get the Facts" brochure; and

6. A statement that pursuant to N.J.S.A. 17B:27A–19, all carriers offering small employer health benefits plans must issue coverage to any small employer group which requests coverage under a small employer health benefits plan, meets the participation requirements of the carrier, and pays the required premium for the coverage.

(f) A withdrawing small employer carrier shall provide at least one copy of its notice of intent to cancel on a date certain or termination on the anniversary of each policy or contract, to the producer of record for each policy or contract. The notice shall be sent by certified mail, no less than six months prior to the effective date of withdrawal.

(g) Simultaneous with its notice to the Commissioner, a withdrawing small employer carrier shall submit a notice to the Board at the address specified at N.J.A.C. 11:21–1.2, which:

1. Indicates that the carrier shall withdraw from the State of New Jersey;

2. States that the carrier will nonrenew its in force policies or contracts on their anniversary date; and

3. Sets forth the date when the nonrenewals shall begin.

(h) Following the initial notice to the small employer, a small employer carrier shall submit subsequent notices to the small employer of the nonrenewal on the anniversary date of the contract and the date upon which the nonrenewal shall occur. Such notice shall be included with each monthly premium bill or premium notice issued prior to the date of nonrenewal. Where no monthly premium statement is transmitted, a small employer carrier shall provide a small employer with no fewer than three notices, which notices shall be sent at a minimum on the sixth, third and last month prior to the date of nonrenewal.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Rewrote the section.
Amended by R.2004 d.108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).

11:21–16.4 Restrictions on writings following a market withdrawal

Any small employer carrier that ceases to do business pursuant to this subchapter shall be prohibited from writing new business in the New Jersey small employer market for a period of five years from the date of termination of the last health benefits plan nonrenewed under this subchapter.

Amended by R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Rewrote the section.

11:21–16.5 General provisions for withdrawal of plan, plan option and copayment/deductible option

(a) No carrier shall cease to issue or nonrenew a standard small employer health benefits plan, plan option or copayment/deductible option required or permitted to be offered pursuant to N.J.A.C. 11:21–3 until the carrier submits a notice of intent to withdraw a plan, plan option or copayment/deductible option with the Commissioner in accordance with the provisions of this subchapter.

(b) A carrier may cease to issue and nonrenew a standard small employer health benefits plan pursuant to this section only if:

1. The copayment/deductible option is not required to be offered pursuant to N.J.A.C. 11:21–3.1(b) or (c); or

2. In the case of a copayment/deductible option required to be offered pursuant to N.J.A.C. 11:21–3.1, the

carrier meets its obligation to offer the standard small employer plans and required copayment/deductible options either by offering the plans as indemnity plans or by making the plan or plans available through or in conjunction with a selective contracting arrangement to all New Jersey small employer groups.

(c) A carrier may cease to issue and nonrenew a standard plan option pursuant to this section by offering another approved plan option. Examples of plan options include, but are not limited to, a carrier's option to calculate the family deductible based on a two times individual or three times aggregate basis, and an HMO's option to offer prescription drug coverage with either a $15.00 copayment or with 50 percent coinsurance.

(d) A carrier that seeks to withdraw a plan, plan option or copayment/deductible option pursuant to this section shall provide the Commissioner with written notification of its intent to withdraw a plan, plan option or copayment/deductible option. An original and two copies of the notice of intent to withdraw a plan, plan option or copayment/deductible option shall be sent to the attention of: SEH Withdrawal Notice, Life and Health Division, New Jersey Department of Banking and Insurance, PO Box 325, Trenton, New Jersey 08625-0325, and shall include the following information:

1. The name of the carrier;

2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for plan, plan option or copayment/deductible option withdrawal;

3. A specific description of the reasons the carrier is withdrawing the plan, plan option or copayment/deductible option;

4. Copies of a nonrenewal notice the applicant intends to send to its policy or contractholders. Nonrenewal notices for policy or contract holders shall include the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option or copayment/deductible option;

ii. The date upon which the plan, plan option or copayment/ deductible option shall be nonrenewed;

iii. A statement that the plan, plan option or copayment/ deductible option is being nonrenewed under the authority of this subchapter;

iv. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option or copayment/deductible option withdrawal; and

v. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan, plan option or copayment/deductible option withdrawal; and

5. Copies of the proposed nonrenewal notices the applicant intends to send to its producers. Nonrenewal notices for producers shall contain the same information as the notices to policy and contract holders.

(e) The Commissioner shall review the notice of intent to withdraw a plan, plan option or copayment/deductible option to determine whether it complies with the filing requirements of (d) above. The Commissioner shall notify the carrier, in writing, of any deficiencies and the requirements that are necessary to bring it into compliance with this section.

(f) A carrier which has submitted a notice of intent to withdraw a plan, plan option or copayment/deductible option shall:

1. Not more than 60 days after the date of the notice of intent to withdraw the plan, plan option or copayment/deductible option, cease issuing the standard small employer health benefits plan, plan option or copayment/deductible option;

2. Not more than 60 days following the date of notice of intent to withdraw the plan, plan option or copayment/deductible option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option or copayment/deductible option, mail a notice, in the same format submitted to the Commissioner pursuant to (d)4 above, to every policy or contract holder, informing the policy or contract holder that the plan, plan option or copayment/deductible option will be nonrenewed on the plan's anniversary date;

3. Following the initial notice to each policy or contractholder, send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium is transmitted, send a notice at least 30 days prior to nonrenewal; and

4. Not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option or copayment/deductible option, mail a notice in the same format submitted to the Commissioner pursuant to (d)5 above, to the producer of record, if any, for each policy or contract.

New Rule, R.2004 d.108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Former N.J.A.C. 11:21-16.5, Penalties, recodified to N.J.A.C. 11:21-16.6.

11:21-16.6 Penalties

Failure to comply with the requirements of this subchapter shall result in the imposition of penalties pursuant to N.J.S.A. 17B:27A-43 and any and all other penalties provided by law.

Recodified from N.J.A.C. 11:21-16.5 by R.2004 d. 108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Former N.J.A.C. 11:21-16.6, Other policyholder rights unaffected, recodified to N.J.A.C. 11:21-16.7.

11:21-16.7 Other policyholder rights unaffected

Nothing in this subchapter shall be construed to contravene any rights of policyholders concerning cancellation requirements or obligations set forth in a policy or contract issued by a small employer carrier.

Recodified from N.J.A.C. 11:21-16.6 by R.2004 d. 108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Former N.J.A.C. 11:21-16.7, Revocation of a notice of intent to withdraw, recodified to N.J.A.C. 11:21-16.8.

11:21-16.8 Revocation of a notice of intent to withdraw

(a) A carrier may revoke its notice of intent to withdraw, filed with the Commissioner pursuant to N.J.A.C. 11:21-16.3, prior to the date that its withdrawal is complete, by submitting a statement to the Department at the address specified at N.J.A.C. 11:21-16.3(c) and to the Board at the address specified at N.J.A.C. 11:21-1.2 revoking its notice of intent to withdraw. The revocation shall be signed by a duly authorized officer, and shall include the following:

1. A statement agreeing to reinstate any small employer that was nonrenewed by the carrier pursuant to the provisions of N.J.S.A. 17B:27A-23e and this subchapter.

New Rule, R.1994 d.580, effective November 21, 1994.
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).
Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (a), changed N.J.A.C. reference in the introductory paragraph, substituted "nonrenewed" for "cancelled, or terminated" in 1, and deleted former 2 through 4.
Recodified from N.J.A.C. 11:21-16.7 by R.2004 d. 108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).

SUBCHAPTER 17. FAIR MARKETING STANDARDS

11:21-17.1 Plan identification and marketing materials

(a) Each small employer carrier which issues marketing and/or promotional materials in conjunction with the standard health benefits plans may attach its own name or identification to each of the plans, but shall also identify each of those standard health benefits plans by the alphabetical designation (A, B, C, D, E, HMO, HMO POS) assigned to it in N.J.A.C. 11:21-3.1. The alphabetical designation shall be clearly identified in the designation of each of the small employer carrier's standard health benefits plans.

(b) All eligibility, coverage and exclusions described in the small employer carrier's marketing and/or promotional material shall be consistent with the Act and this chapter.

Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted "standard" preceding "health benefits plan" throughout and inserted reference to HMO POS.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Deleted former (c).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b), substituted " eligibility, coverage and exclusions described" for "terms, definitions, and text used".

11:21-17.2 Retention of marketing and promotional materials

Small employer carriers shall maintain a complete file of all marketing and promotional material specific to the health benefits plans, which it disseminates to consumers, producers, or otherwise publicly disseminates. Small employer carriers shall retain each piece of promotional and marketing materials for a period of three calendar years from the last date the material is publicly disseminated, which shall be deemed its complete file for the purposes of this subchapter. Upon written request of the Board, a small employer carrier shall, within three business days, make available for inspection its complete file of marketing and promotional material to the Board.

11:21-17.3 Certification

(a) Each small employer carrier disseminating marketing and promotional material shall certify that its marketing and promotional material conforms with the requirements of this subchapter. The certification, set forth in Part 2 of Exhibit BB of the Appendix, incorporated herein by reference, shall be signed by a duly authorized officer of the small employer carrier. Each small employer carrier shall file its initial certification with the Board no later than the first day upon which the small employer carrier disseminates promotional or marketing materials for the health benefits plans to consumers, producers or the public in general.

(b) Small employer carriers shall continue to file a certification as required in (a) above on an annual basis, on or before March 1 of each year following the filing of its initial certification.

Amended by R.1994 d.153, effective February 28, 1994.
See: 26 N.J.R. 741(a), 26 N.J.R. 1352(a).
Amended by R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
In (a), inserted "carrier" preceding "disseminates promotional or marketing"; and in (b), inserted March 1 deadline.
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

In (a), deleted ", or by February 15, 1994, whichever date is later" at the end.

11:21-17.4 (Reserved)

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Substituted references to a "Get the Facts" brochure for references to a Buyer's Guide throughout.
Repealed by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5071(a), 36 N.J.R. 1594(a).
Section was "Get the Facts" brochure.

11:21-17.5 Producer contracts

(a) A small employer carrier may select those insurance producers, as defined by N.J.S.A. 17:22A-2j, with whom it chooses to contract. No small employer carrier shall terminate or refuse to renew the contract of its insurance producers because of health status-related factors of eligible employees or dependents, the average number of eligible employees or the average number of employees enrolled in small employer plans placed by the producer with the carrier, or the occupation or geographic location of the small employer groups placed by the insurance producer with the small employer carrier.

(b) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an insurance producer that provides for or results in any consideration provided to an insurance producer for the issuance or renewal of a small employer health benefits plan that varies on account of health status-related factors of eligible employees or dependents, the number of eligible employees or the number of employees enrolled, or the industry, occupation or geographic location of a small employer covered by a small employer health benefits plan.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), and (b), substituted "health status-related factors of eligible employees or dependents, or the" for "the health status, claims experience,".
Amended by R.2000 d.67, effective January 26, 2000 (operative April 1, 2000).
See: 32 N.J.R. 168(a), 32 N.J.R. 708(b).
In (b), inserted "the number of eligible employees or the number of enrollees," following "or dependents,".
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), rewrote the second sentence; in (b), substituted "employees enrolled" for "enrollees" following "the number of".

SUBCHAPTER 18. PETITIONS FOR RULES

11:21-18.1 Scope

This subchapter shall apply to all petitions made by interested persons for the promulgation, amendment or repeal of any rule by the Board, pursuant to N.J.S.A. 52:14B-4(f).

11:21-18.2 Procedure for petitioner

(a) Any person who wishes to petition the Board to promulgate, amend or repeal a rule shall submit to the Board, in writing, the following information:

1. Name and address of the petitioner;

2. The substance or nature of the rulemaking which is requested;

3. The reasons for the request and the petitioner's interest in the request;

4. References to the statutory authority of the Board to take the requested action; and

5. A caption at the top of the document identifying it as a petition for rulemaking pursuant to N.J.S.A. 52:14B-4(f) and this subchapter.

(b) The petition shall be sent to the Executive Director at the address in N.J.A.C. 11:21-1.3.

(c) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

(d) Any document submitted to the Board which is not in substantial compliance with (a) above shall not be deemed to be a petition for a rule requiring further Board action pursuant to N.J.S.A. 52:14B-4(f).

Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (a), added 5; added a new (b) and recodified former (b) and (c) as (c) and (d).

11:21-18.3 Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:21-18.2 the Board shall, within 15 days, file a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;

2. The substance or nature of the rulemaking action which is requested;

3. The problem or purpose which is the subject of the request; and

4. The date the petition was received.

(b) Within 60 days of receiving a petition in compliance with N.J.A.C. 11:21–18.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;

2. The New Jersey Register citation for the notice of petition, if that notice appeared in a previous New Jersey Register;

3. Certification by the Board that the petition was duly considered pursuant to law;

4. The nature or substance of the Board's action upon the petition; and

5. A brief statement of reasons for the Board's action.

(c) Board's action on a petition may include:

1. Denying the petition;

2. Filing a notice of proposed rule or a notice of preproposal for a rule with the Office of Administrative Law; or

3. Referring the matter for further deliberations, the nature of which shall be specified and which shall conclude upon a specified date. The results of these further deliberations shall be mailed to petitioner and submitted to the Office of Administrative Law for publication in the New Jersey Register.

Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
In (a), inserted ", within 15 days," following "shall" in the introductory paragraph.
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).
In (b), substituted "60" for "30" in the introductory paragraph.

SUBCHAPTER 19. SEH PROGRAM PREMIUM COMPARISON SURVEY

11:21–19.1 Purpose and scope

(a) This subchapter requires the annual submission of data by small employer carriers to the Department, and establishes the format for the submission of such data, regarding premiums charged for the five standard health benefits plans, the HMO plan, the HMO/POS plan, and any standard rider packages established by the Board, so that the Department may develop and publish an annual SEH Program Premium Comparison Survey, pursuant to N.J.S.A. 17B:27A–33g.

(b) This subchapter shall apply to all small employer carriers.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (a), inserted a reference to HMO/POS plans.

11:21–19.2 Definitions

The following words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1.2, unless defined below or the context clearly indicates otherwise.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board subject to review and approval by the Commissioner.

"Standard rider" means a rider promulgated by the SEH Board to be offered with one or more of the standard health benefits plans.

11:21–19.3 SEH Program premium comparison survey

(a) Every small employer carrier shall prepare and file with the Department a premium survey reflecting premiums charged for each of the five standard small employer health benefits plans, the HMO plan, the HMO/POS plan, and for any standard rider packages, as set forth in Exhibit FF of the Appendix to this chapter, incorporated herein by reference.

(b) Every small employer carrier shall complete the survey in the format set forth in Exhibit FF in accordance with the instructions set forth therein, and shall not vary the information solicited in Exhibit FF.

(c) Completed survey forms shall be filed no later than November 1 of each year, and shall reflect the monthly premiums to be charged for each of the five standard health benefits plans, the HMO plans, the HMO/ POS plans, and any standard rider packages as of January 1 of the year immediately following.

(d) All filings shall be accompanied by the following certification signed by the person who completed the survey: "I _____ certify that the information set forth in the attached SEH Program Premium Comparison Survey is true and accurate, and hereby further certify that I am authorized to execute this certification on behalf of the carrier named in the survey."

(e) Completed survey forms and signed certification shall be filed with the Department pursuant to this subchapter at the following address:

SEH Program Premium Comparison Survey
Public Affairs Office
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, New Jersey 08625–0325

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

In (a) and (c), inserted references to HMO/POS plans; in (c), deleted a former second sentence; deleted a former (d); recodified former (e) and (f) as (d) and (e); and in the new (e), updated the address.

11:21-19.4 Penalties

Failure to comply with the requirements of this subchapter may result in the imposition of penalties as authorized by N.J.S.A. 17B:27A-43.

Amended by R.2004 d.108, effective March 15, 2004.
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).
Amended the N.J.S.A. reference.

SUBCHAPTER 20. WITHDRAWALS OF STANDARD SEH PLAN OPTIONAL BENEFIT RIDERS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17B:27A-17 et seq.

Source and Effective Date

R.2004 d.149, effective March 18, 2004.
See: 36 N.J.R. 145(a), 36 N.J.R. 1942(a).

Subchapter Historical Note

Subchapter 20, Withdrawals of Standard SEH Plan Optional Benefit Riders, was adopted as R.1999 d.156, effective May 17, 1999. See: 31 N.J.R. 109(a), 31 N.J.R. 1357(a).

Subchapter 20, Withdrawals of Standard SEH Plan Optional Benefit Riders, was readopted as R.2004 d.149, effective March 18, 2004. See: Source and Effective Date.

11:21-20.1 Purpose and scope

(a) The purpose of this subchapter is to establish standards and procedures for carriers to withdraw standard SEH plan optional benefit riders.

(b) This subchapter applies to all riders to a standard SEH plan filed with the Commissioner or the SEH Board pursuant to N.J.S.A. 17B:27A-19i(1).

11:21-20.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A-17 or N.J.A.C. 11:21-1.2 unless defined below or the context clearly indicates otherwise.

"Optional benefit rider" means a rider to a standard SEH plan or plans filed with the Commissioner and/or the SEH Board pursuant to N.J.S.A. 17B:27A-19i(1).

"Small employer health benefits program" or "SEH" means the New Jersey Small Employer Health Benefits Program established pursuant to section 12 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-28).

11:21-20.3 Withdrawal of optional benefit riders

(a) A carrier seeking to withdraw an optional benefit rider to a standard SEH plan that has been filed with the Commissioner and/or the Board pursuant to N.J.S.A. 17B:27A-19i(1) shall first obtain the Commissioner's approval by complying with all of the requirements of this subchapter.

(b) A carrier seeking to withdraw an optional benefit rider shall prior to withdrawal of the optional benefit rider submit a written application to the Commissioner as follows:

1. The written application shall include the following:

i. The name of the carrier;

ii. The name, address, telephone number and fax number of the carrier's representative responsible for the application to withdraw the optional benefit rider;

iii. The reason(s) the carrier is withdrawing the optional benefit rider;

iv. The number of inforce plans affected by the withdrawal;

v. A copy of the nonrenewal notice the carrier shall provide to policyholders or contractholders as described in (c) below;

vi. A copy of the nonrenewal notice the carrier shall provide to producers as described in (d) below; and

vii. A copy of the optional benefit rider the carrier is withdrawing, along with evidence of approval of the rider by the Department or acknowledgment of the rider by the SEH Board.

2. The completed application shall be sent to the following address:

New Jersey Department of Banking and Insurance
Life and Health Division
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

3. The Department shall review the completed application for compliance with the requirements of this section, and shall provide the carrier within 30 days of receipt with written notice of any deficiencies in the application or with an acknowledgment that the application is complete and in compliance with the requirements of this section.

4. The carrier shall return to the Department an amended application correcting any deficiencies within 30 days of receipt of the Department's deficiency notice.

5. The carrier shall cease issuing the optional benefit rider no later than 60 days after the date that acknowledgment of a complete application to withdraw the optional benefit rider is received.

EXHIBIT C

(RESERVED)

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Recodified as a part of Exhibit F by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Was "Schedule of Insurance and Premium Rates [Plan C]".

EXHIBIT D

OVER-AGE DEPENDENT COVERAGE RIDER

[Policy]holder:
Group Policy No:
Effective Date:

This Rider amends the Group [Policy] and the [Certificates] issued to over-age dependents who elected coverage under the **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** provision.

I. The **DEPENDENT COVERAGE** section is deleted in its entirety and replaced with the following section entitled **OVER-AGE DEPENDENT COVERAGE**.

OVER-AGE DEPENDENT COVERAGE

Eligible Dependents

An Employee's child by blood or law who:
a) has reached the limiting age of 19 or 23, as applicable, but is less than 30 years of age;
b) is not married;
c) has no Dependents of his or her own;
d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and
e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare.

Enrollment Requirement

To continue group health benefits, the Over-Age Dependent must make written election to [the Carrier].

For a Dependent whose coverage has not yet terminated due to the attainment of age 19 or 23, as applicable, the written election must be made within 30 days prior to termination of coverage due to the attainment of age 19 or 23.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election must be made within 30 days after the person first subsequently meets all of the requirements for an Over-Age Dependent.

This election opportunity is explained in greater detail as follows:
a) If a person did not qualify because he or she was married, the notice must be given within 30 days of the date he or she is no longer married.
b) If a person did not qualify because he or she had a Dependent of his or her own, the election must be made within 30 days of the date he or she no longer has a Dependent.
c) If a person did not qualify because he or she either was not a resident of New Jersey or was not a full-time student at an Accredited school, the election must be made within 30 days of the date he or she becomes a resident of New Jersey, or becomes a full-time student at an accredited school.
d) If a person did not qualify because he or she was covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or was entitled to Medicare, the election must be made within 30 days of the date he or she is no longer covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or is no longer entitled to Medicare.

An Over-Age Dependent may make written election to continue coverage during a 30 day period beginning on each anniversary date of the date the dependent lost coverage due to attaining the limiting age, provided he or she meets the definition of an "Over-Age Dependent" during that 30-day period.

[A person who qualifies as an Over-Age Dependent as of May 12, 2006, having reached the limiting age under a group plan and lost coverage under such group plan prior to May 12, 2006, may give written notice of an election for continued coverage at any time beginning May 12, 2006 and continuing until May 11, 2007.]
Note to carriers: This paragraph may be deleted for riders issued after May 11, 2007.

When Over-Age Dependent Coverage Starts
The effective date of the continued coverage will be the later of:
a) the date the Over-Age Dependent gives written notice to [the Carrier]; or
b) the date the Over-Age Dependent pays the first premium; or
c) the date the Dependent would otherwise lose coverage due to attainment of the limiting age.

When Over-Age Dependent Coverage Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:
a) the date the Over-Age Dependent:
   1. attains age 30;
   2. marries;
   3. acquires a Dependent;
   4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
   5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare
b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;

c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

II. Coverage for an Over-Age Dependent is single coverage. Any Deductible, Coinsurance and/or Copayments paid by an Over-Age Dependent is independent of any Deductible, Coinsurance and/or Copayments paid by the Over-Age Dependents parents, or siblings. Any provision in the Group [Policy] [and] [,] [Certificate] [and optional benefit rider] allowing for a family deductible or a family Maximum Out of Pocket does not apply to the coverage for the Over-Age Dependent.

III. The following provisions are deleted in their entirety:
a) COBRA CONTINUATION RIGHTS,
b) NEW JERSEY GROUP CONTINUATION RIGHTS,
c) A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS,
d) AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE,
e) A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS
f) CONVERSION RIGHTS FOR DIVORCED SPOUSES
g) COORDINATION OF BENEFITS AND SERVICES

This rider is part of the [Policy]. Except as stated above, nothing in this rider changes or affects any other terms of the [Policy].

Petition for Rulemaking.
See: 26 N.J.R. 5120(c).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Recodified as a part of Exhibit F by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Was "Schedule of Insurance and Premium Rates [Plan D]".
New Rule, R.2006 d.377, effective September 22, 2006.
See: 38 N.J.R. 3484(a), 38 N.J.R. 4719(b).

EXHIBIT J

(RESERVED)

Amended by R.1994 d.498, effective September 2, 1994.
See: 26 N.J.R. 2843(a), 26 N.J.R. 3867(a), 26 N.J.R. 4066(a).
Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).
Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Repealed by R.2003 d.24, effective January 21, 2003 (operative June 1, 2003).
See: 34 N.J.R. 648(a), 35 N.J.R. 442(a).

EXHIBIT K

EXPLANATION OF BRACKETS

Plans A through E Policy and Certificate
(Appendix Exhibits A and V for Plan A and F and W for Plans B – E)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does not give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following 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
e) Some areas of variability are determined by the election made by a Carrier.
f) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
g) Some areas of variability are determined by the delivery system (i.e., indemnity, PPO or POS)
h) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.
i) Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO or POS plans, explicit guidance is set forth in item 27 below. Similarly, explicit guidance for the issuance of a Dual Contract POS product is set forth in item 30 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets for the HMO plan, which appears later in this document, for guidance on the variable text that appears in the HMO form that would be issued in conjunction with the indemnity form to produce the Dual Contract POS Plan.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy and certificate forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that could pay dividends.
2. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
3. Although the schedule pages specify the plan letter in the upper right corner this identification is intended solely to identify which plan letter the page illustrates. Carriers need not specify the plan letter on the schedule pages of plans being issued.
4. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
5. If a Carrier elects to provide for a family deductible and family maximum out of pocket allowing for an aggregate satisfaction as opposed to an individual satisfaction, the variable schedule text addressing individual satisfaction would be deleted. The appropriate multiple of the individual deductible and maximum out of pocket must be included. The BENEFIT PROVISION of the HEALTH BENEFITS INSURANCE provision includes text for both an individual and an aggregate satisfaction. Carriers should include text consistent with the text included on the Schedule. **Note:** ALL plans issued by a Carrier MUST include the same option.
6. There are alternate PPO and POS schedule pages that allow carriers to use separate or common deductible and maximum out of pocket provisions. These features may be used, at the option of the carrier. There are corresponding provisions in the benefit provisions.
7. The list of services and supplies for which pre-approval is required includes two new items, included in brackets: specified therapies and prescription drugs. The benefit provisions for these services and supplies also includes text in brackets concerning pre-approval. Carriers that elect to require pre-approval for these services and supplies must include them on the list on the schedule page in addition to using the pre-approval text in the benefit provision.
8. The Reinstatement provision may be included or omitted, at the option of the carrier. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
9. 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.

10. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
11. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
12. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the policy form.
13. The definition of Referral should be included in POS plans that require referrals.
14. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
15. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.
16. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation. The text may address a date certain following a waiting period, such as first of the month following 3 months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
17. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
18. The text describing provider compensation in the PPO and POS sections contains a number of bracketed words and phrases. Include the words and phases that describe the arrangement carrier has with network providers.
19. The continuation of care text must be included in all plans that use networks.
20. The treatment of hemophilia provision includes variable text that would only be included in PPO and POS plans.
21. The prescription drugs provision includes variable text that would be included by carriers that require pre-approval for specified drugs.
22. The therapy services provision includes variable text that would be included by carriers that require pre-approval for certain therapy services.
23. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. For Carriers electing to include the optional cancer treatment benefits as part of the standard forms, the list of services for which Pre-Approval is required, as it appears in the Schedule of Benefits, must be modified to omit the item for autologous bone marrow transplant and associated dose intensive chemotherapy. **NOTE:** A Carrier may make separate elections regarding the optional benefit for Plan A and B-E to either include as part of the standard plans or offer as a rider.
24. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty.
25. The Specialty Case Management provision may be omitted. Carriers may administratively provide for such provisions. If included in the policy and certificate, the text must conform to the text of the standard form.
26. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.
27. Carriers that issue plans through or in conjunction with an approved Selective Contracting Arrangement must consider the following when creating the plan documents:
    a. The policy and certificate documents contain "SAMPLE" schedule page text. The dollar amounts for the deductibles and copayments are purely illustrative. Refer to N.J.A.C. 11:21-3(d) for direction as to which amounts may be substituted for those in the example. For plans that utilize a copay feature, the copays replace the cash deductible for the particular service, and benefits following the copay must be paid at 100%. The dollar amounts for the copays must be consistent with those that an HMO carrier may use. ($5, $10, $15, $20, $30, $40 or $50)
    b. Include the specific page of text describing either the PPO or the POS mechanism, with specification of the name of the network or provider organization.
28. Carriers that intend to use the standard indemnity forms as the non-network portion of a Dual Contract POS plan must consider the following when creating the plan documents:

Only Plans C and D may be used to provide the non-network benefits. Plans C and D must be issued as pure indemnity plans. That is, they may **not** be plans issued through or in conjunction with a Selective Contracting Arrangement.

Throughout the text, variable text which begins with "DC" appears. **All** of the variable text which is designated as "DC" text must be included when indemnity plans C or D are used as the non-network portion of a Dual Contract POS plan. **All** of the text designated with "DC" is essential to accomplish the intended integration of the indemnity plan with the HMO plan to produce the Dual Contract POS product.

In **addition** to the above items, Carriers must consider the following in connection with the certificate forms:

29. The face page text may be modified to be consistent with a carrier's methods of certificate personalization The certificate level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the certificate. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
30. The term "certificate" may be replaced with certificate booklet, certificate of insurance, employee booklet, booklet certificate, evidence of coverage, or similar titles used to identify the document provided to employees insured under an employer's group plan.
31. Variable schedule data such as deductible, and copayment amounts may be included on the schedule, shown on the face page, sticker or separate schedule.
32. The Payment of Premiums-Grace Period section may be omitted, at the carrier's option.
33. The definition of "You, Your and Yours" may be omitted by carriers that elect to refer to the employee as Employee, rather than use the personal "You". Throughout the text, the words "You," "Your" and "Yours" must be replaced with "Employee" terminology.

Plan HMO Contract and Evidence of Coverage
(Appendix Exhibits G and Y)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does *not* give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], 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.
e) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
f) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.
g) Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.

Note: Explicit guidance for the issuance of a Dual Contract POS product is set forth in item 18 below. Carriers that issue a Dual Contract POS product should refer to the above explanations for Plans C and D for guidance on the variable text that appears in the indemnity form that would be issued in conjunction with the HMO form to produce the Dual Contract POS plan.

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 and Evidence of Coverage forms.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name fax and e-mail numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.
3. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
4. Deductible, coinsurance and maximum out of pocket provisions may be included for network benefits. Applicable text to address the deductible, coinsurance and maximum out of pocket features must be included on the schedule page and in the benefit provisions.
5. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
6. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE:** ALL plans issued by a Carrier must make the optional benefit available in the same manner.
7. The bracketed dispensing limit text contained in the prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
8. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
9. OB/GYNs can be considered Primary Care Physicians.
10. Eligible class references can be removed.

11. 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. The text may address a date-certain following a waiting period, such as first of the month following 3 months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
12. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
13. Percentage participation requirement 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.
14. Transfer of Primary Care Physician can occur according to carrier administration, but may not be more restrictive to the member than stated in the form.
15. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
16. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
34. The Reinstatement provision should be included by carriers that will allow reinstatement. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
17. Carriers that intend to use the standard indemnity forms as the network portion of a Dual Contract POS plan must consider the following when creating the plan documents:

Throughout the text, variable text which begins with "DC" appears. *All* of the variable text which is designated as "DC" text *must* be included when the HMO plan is used as the network portion of a Dual Contract POS plan. *All* of the text designated with "DC" is essential to accomplish the intended integration of the indemnity plan with the HMO plan to produce the Dual Contract POS product.

In addition to the above items, Carriers must consider the following in connection with the evidence of coverage forms:

18. The face page text may be modified to be consistent with a carrier's methods of evidence of coverage personalization. The evidence of coverage level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the document. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
19. The term "evidence of coverage" may be replaced with a similar term used to identify the document provided to employees covered under an employer's group plan.

Plan HMO-POS Contract and Evidence of Coverage
(Appendix Exhibits HII and II)

All text which is enclosed in brackets is variable. Enclosure in Brackets does not give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in five ways.

1. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], [date].
2. Some areas of variability are noted with brief explanations within the text.
3. Some areas of variability are intended to allow for flexibility in terms of a Carrier's administrative practices.
4. Some areas of variability are subject to ranges specified in statute or regulation.
5. Some areas of variability are determined by Carrier elections. [Examples include the use of a care manager, health center, and terms to identify the member, network and non-network benefits.]
6. Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.

The following explanations apply to the Contract and Evidence of Coverage, unless otherwise stated.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.

3. The forms define and use the terms "Network" or "In-Network" and "Non-Network" or "Out-of-Network." Carriers may replace those terms as they appear in the definitions section, and elsewhere throughout the forms, with alternate terms.-(Example: Participating, Non-Participating)
4. The forms define and use the term "Member." Carriers may replace that term as it appears in the definitions section, and elsewhere throughout the forms, with an alternate term. (Examples: Subscriber, Enrollee)
5. The plan may be issued as employee only coverage. Text which addresses dependent coverage, as enclosed in brackets, may be deleted for plans which only make coverage available to employees.
6. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
7. Copayment, deductible, coinsurance and maximum out of pocket amounts may be elected by the Contractholder, subject to the availability specified in regulation. The applicable schedule page and benefit provision text should be included, consistent with whether deductible and coinsurance provision applies to both network and non-network benefits or only to non-network benefits.
8. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
9. Carriers that do not use a "Care Manager" should omit the definition of Care Manager, and omit the term as it appears throughout the text.
10. The definition of "Employer" should identify the name of the employer or specify the location in the Contract and Evidence of Coverage where the employer name is specified.
11. Carriers that do not use "Health Care Centers or Health Centers" should omit the definition of Health Care Centers or Health Centers, and omit the terms as they appear throughout the text.
12. The "Waiting Period" provision may be omitted, or included, at the option of the Contractholder. If included, the duration of the waiting period may not exceed six months, as set forth in N.J.A.C. 11:21-7.9(c). The text may address a date certain following a waiting period, such as first of the month following 3 months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
13. The date employee or dependent coverage begins or ends may vary, to accommodate Contractholder, or Carrier administration practices. (Example: Coverage may begin as of the first of the month following any waiting period. Coverage may end immediately, or at the end of the month in which the termination event occurs.)
14. The Selection or Change of a Primary Care Physician or Health Center, and the effective date of the selection or transfer may vary according to Carrier administration, but may not be more restrictive to the member than stated in the form.
15. Carriers that do not have a home care program that satisfies the requirements of the New Jersey "48 hour maternity" statute, (P.L.1995, c.138) should omit the reference to such program in the text of the Inpatient Hospice, Hospital, Rehabilitation Center & Skilled Nursing benefits section of the plan.
16. Carriers may elect to make the optional cancer treatment benefit available as part of the standard plan or as an optional benefit rider. The selected option determines which text the Carrier should include. *Note*: All plans issued by a Carrier must reflect the same Carrier election to either include the optional benefit, or make the benefit available by rider.
17. Carriers may elect to calculate the non-network family deductible as two times the individual deductible, calculated on a per individual basis, or as three times the individual deductible, calculated on an aggregate basis. The Schedule and the Non-Network Benefit provision must reflect the selected calculation. *Note*: All plans issued by a Carrier must reflect the same election.
18. The bracketed dispensing limit text contained in the network prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
19. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
20. Carriers that wish to apply pre-approval requirements to non-network prescription drug coverage should include the variable pre-approval text.
21. The Pre-Existing Conditions exclusion may be omitted.
22. The Utilization Review Features may be omitted in its entirety, or specific sections may be omitted. The penalty for non-compliance may be adjusted to specify a percentage or a dollar penalty. A Carrier that wishes to use alternate text to describe utilization review provisions must submit the text to the Board and the Department of Insurance, pursuant to N.J.A.C. 11:21-4.2.
23. The "Specialty Case Management" provision may be omitted. Carriers may provide for such "case management" administratively. If included in the form, the text must conform to the text of the standard form.
24. The "Centers of Excellence" provision may be omitted. If included in the form, the text must conform to the text of the standard form.
25. Percentage participation requirements (specified as 75% in the forms) may be modified by the Carrier, provided the Carrier complies with N.J.A.C. 11:21-7.6.
26. The Reinstatement provision should be included by carriers that will allow reinstatement. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
27. The "Notice of Loss" section of the "Claims Provisions" may be omitted, at the option of the Carrier.
28. The third sentence of the "Payment of Claims" section of the "Claims Provisions" should be omitted, if not applicable.

The following explanations apply only to the Evidence of Coverage.

1) The face page of the Evidence of Coverage may be modified to reflect a Carrier's method of personalization. Only that text which pertains to the manner of identifying the covered person may be modified.
2) The term "Evidence of Coverage" may be replaced with another term which the Carrier uses to name the document given to covered persons. If another name is used, the Carrier should make similar name changes in the corresponding Contract form.
3) The Introduction contains bracketed areas which should be omitted, if not applicable, or modified to specify appropriate information.

Prescription Drug Rider
(Appendix Exhibit H)

All text which is enclosed in brackets [] is variable.

This rider is designed to be used with both HMO and non-HMO based plans. Policyholder can be changed to read Contractholder, as appropriate. Covered person can be changed to read Member, as appropriate.

Some areas of variability are self-explanatory. Examples include: [Carrier] and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the copayment text.

The rider can be used to provide a card only benefit, a mail only benefit, a card/mail benefit. It can be used to require pre-approval for certain drugs. It can also be used to specify different levels of benefits for preferred v. non-preferred drugs.

Employer Application
(Appendix Exhibit N)

1. Contractholder or Planholder and Contract or Plan, as appropriate.
2. The terms Policyholder and Policy may be replaced with terms insurance and insured may be replaced with coverage and covered, as appropriate.
3. The reference to Automatic Checking Withdrawal may be deleted if Carrier does not offer such options.
4. The text of the Health Benefits section may vary to accommodate the options a Carrier will offer, including optional benefit riders. For example, if a Carrier does not offer HMO plans, such text may be deleted.
5. Agent/Producer information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.
6. If benefits are to be issued through a Multiple Employer Trust, a Carrier may include text which specifies that the employer is requesting participation in a Trust.
7. If a Carrier provided coverage to a small employer's employees working fewer than 25 hours per week and/or retirees under a health benefits plan issued prior to January 1, 1994, and such Carrier elects to continue to cover part-time employees and/or retirees after January 1, 1994, under the terms and conditions outlined in N.J.A.C. 11:21.7.3(e) and (f), the text of the first 2 sentences of the Signature section may be adjusted to reflect the expanded eligibility.
8. If a carrier elects to allow applications to be submitted electronically, the signature lines on the application may be omitted. However, New Jersey's Insurance Code does not specifically address the use of electronic mediums for the application process. It is the carrier's responsibility to comply with all existing New Jersey statutes, regulations and pertinent case law dealing with general contract law or electronic signatures to determine acceptability of any electronic application process. The carrier is cautioned, however, that the use of such mediums may result in the waiving of or limitations in the Carrier's right to contest coverage or limit benefits for pre-existing conditions. The existence of variable material on the standard application form should not be construed as acceptability of the electronic process.

Amended by R.1994 d.47, effective December 22, 1993.
See: 25 N.J.R. 5017(a), 26 N.J.R. 400(a).

Amended by R.1995 d.580, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3051(a), 27 N.J.R. 4371(a).

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Repeal and New Rule, R.2004 d.107, effective March 15, 2004 (operative October 1, 2004).
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.2000 d.304, effective June 23, 2000.
See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

EXHIBIT O

EMPLOYER CERTIFICATION

"Carrier's Logo"

Legal Name and Address of Company	Group Policy Number or Group Number (if a current customer)

Group Health Benefits Policy Participation

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work Location (list by State)	Number of Employees				
	Full-time	Part-time	Retired	COBRA or State Continuees	Other

(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _____
Total # Eligible Employees applying/enrolling for health benefits coverage _____
Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, or any other Health Benefits Plan offered by the employer _____
Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage; or any other Health Benefits Plan offered by the employer _____
Total # Employees in an ineligible class or classes _____

Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? Yes No
(You *may* be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)

Is your firm subject to the requirements of the federal COBRA law? Yes No
(You *may* be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B
For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

"Small Employer" means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed an average of at least two, but not more than 50, eligible Employees on business days during the preceding Calendar Year, and
- employs at least two Employees on the first day of the Plan Year, and
- the majority of the Employees are employed in New Jersey.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

I certify that I qualify as a Small Employer in the State of New Jersey.

AND

I certify that the information provided to "Carrier" is true and complete. I understand that if the above information is not complete or is not provided to "Carrier" in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

_____

Signature of Officer, Partner or Owner Title Date

_____

Print Name of Officer, Partner or Proprietor

_____ _____

Signature of Witness Date

I certify that I am NOT a Small Employer in the State of New Jersey as defined above.

_____ _____ _____

Signature of Officer, Partner or Proprietor Title Date

_____

Print Name of Officer, Partner or Proprietor

_____ _____

Signature of Witness Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

***EMPLOYEE CENSUS INFORMATION**

Please include the following persons in the following list:

a employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary employee
I: Independent Contractor
D: Totally Disabled employee
C: Continuce under state or federal law
U. Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

	Name	Job Title	Date of Employment	Hours worked per week	Status	Work Location (State)	Gender	Date of Birth
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								

*If additional space is needed, attach a separate sheet.

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).
Amended by R.1997 d.501, effective January 1, 1998.
See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.2004 d.107, effective March 15, 2004.
See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

EXHIBIT P

(RESERVED)

EXHIBIT FF

SEH PROGRAM PREMIUM COMPARISON SURVEY

Submit this completed survey in duplicate no later than November 1 of each year to: SEH Program Premium Comparison Survey, Public Affairs Office, New Jersey Department of Banking and Insurance, 20 West State Street, PO Box 325, Trenton, NJ 08625-0325.

Part 1
COMPANY AND RESPONDENT INFORMATION

Company Name: _____

NAIC #: _____

Respondent's Name: _____

Respondent's Title: _____

Respondent's Address: _____

Respondent's Telephone: _____

Respondent's Facsimile: _____

Part 2
TOLL-FREE INFORMATION

Company's Toll-Free Telephone number where an applicant may obtain a premium quote:

Please indicate if a switchboard or message recording is reached by the toll-free number and the respective period of service:

Switchboard Service Times: _____

Message Recording Service Times: _____

Part 3
DIRECTIONS FOR COMPLETING THE PREMIUM SURVEY

A. Specify the monthly premium, rounded to the nearest whole dollar, that will be charged for a standard policy issued on the next January 1 to an employer as set forth in paragraph C below, for each policy form and rider in the categories listed in the survey for each plan in accordance with paragraph D below. In showing the rider premium, list only the additional premium for a rider, not the total premium for a plan including the rider. The following abbreviations apply:

SCA = Selective Contracting Arrangement (that is, an arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations (see N.J.A.C. 11:4-37.2)) offered in conjunction with Plan(s) A, B, C, D, or E.
POS = The standard HMO Point of Service plan (HMO/POS plan).
NR = The plan is offered or purchased without any standard riders.
PC = The prescription card rider (Exhibit H or J, Part 2 of the Appendix to N.J.A.C. 11:21).
PM = The prescription mail order rider (Exhibit H or J, Part 3 of the Appendix to N.J.A.C. 11:21).
PMC = The prescription card and mail order rider (Exhibit H or J, Part 1 of the Appendix to N.J.A.C. 11:21).
MH = The mental/nervous and substance abuse rider (Exhibit I of the Appendix to N.J.A.C. 11:21).

B. Use "NA" to indicate when any rider or plan variation is not being offered.

C. For purposes of completing the survey, assume the following policyholder:

Three small employers, one of each employer being located in the following counties: Camden, Middlesex, and Bergen, and each with six employees as follows:

1. Single Female—age 27
2. Single Male—age 37
3. Female Parent—age 47, with two children
4. Male Employee and Spouse—both age 57
5. Male Employee—age 27
   Spouse—age 24
   Two children—both under age 18
6. Female Employee—age 47
   Spouse—age 50
   Two children—both under age 18

D. For purposes of completing the survey, show the premium for only one delivery system option as described on the form, and indicate by checking the appropriate space if other delivery systems for the plan are available.

Part 4
PREMIUM SURVEY

PLAN A

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—

PLAN A PREMIUM 1/1/____

Camden	NR
$250	$_____
Middlesex	
$250	$_____
Bergen	
$250	$_____

Premium Rate Guarantee Period (if any): _____

PLAN B

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN B PREMIUM 1/1/____

Camden	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____
Middlesex					
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____
Bergen					
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

PLAN C

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN C PREMIUM 1/1/____

Camden	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____
Middlesex					
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____
Bergen					
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

PLAN D

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN D PREMIUM 1/1/____

Camden	NR	PC	PM	PMC	MH
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____
Middlesex					
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____
Bergen					
$250	$_____	$_____	$_____	$_____	$_____
$500	$_____	$_____	$_____	$_____	$_____
$1,000	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

PLAN E

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
PLAN E PREMIUM 1/1/____

Camden	NR	PC	PM	PMC	MH
$150	$_____	$_____	$_____	$_____	$_____
Middlesex					
$150	$_____	$_____	$_____	$_____	$_____
Bergen					
$150	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

HMO PLAN

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
HMO PLAN PREMIUM 1/1/____

Camden	NR	PC	PM	PMC	MH
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____
Middlesex					
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____
Bergen					
$5	$_____	$_____	$_____	$_____	$_____
$10	$_____	$_____	$_____	$_____	$_____
$15	$_____	$_____	$_____	$_____	$_____
$20	$_____	$_____	$_____	$_____	$_____

Premium Rate Guarantee Period (if any): _____

HMO/POS PLAN

Carrier: _____

SEH PROGRAM PREMIUM COMPARISON SURVEY—
HMO/POS PLAN PREMIUM 1/1/____

Camden	Plan C Coinsurance	Plan D Coinsurance
$5	$ _____	$_____
$10	$ _____	$_____
$15	$ _____	$_____
$20	$ _____	$_____
Middlesex		
$5	$ _____	$_____
$10	$ _____	$_____
$15	$ _____	$_____
$20	$ _____	$_____
Bergen		
$5	$ _____	$_____
$10	$ _____	$_____
$15	$ _____	$_____
$20	$ _____	$_____

Premium Rate Guarantee Period (if any): _____

DELIVERY SYSTEMS (Plans A through E)

Provide the information below for the rates provided for each plan. For example, if the rates you have provided for Bergen County for Plan D are for a selective contracting arrangement without a gatekeeper, then complete the column labeled "SCA—No Gatekeeper" for that plan and leave the columns labeled "Traditional" and "SCA—Gatekeeper" blank; if the rates provided are not subject to a selective contracting arrangement, then check the appropriate space under the column labeled "Traditional" and leave the SCA columns blank.

Then indicate whether each plan is offered with a different delivery system from that for which information has been provided by circling "yes" or "no" under "Other Delivery Systems Available."

		SCA—No Gatekeeper Coinsurance			SCA—Gatekeeper Coinsurance			Other Delivery Systems Available	
	Traditional	In	Out	Copay	In	Out	Copay		
CAMDEN									
Plan A	_____	*__%	*__%	$_____	*__%	*__%	$_____	yes	no
Plan B	_____	____%	____%	$_____	____%	____%	$_____	yes	no
Plan C	_____	____%	____%	$_____	____%	____%	$_____	yes	no
Plan D	_____	____%	____%	$_____	____%	____%	$_____	yes	no
Plan E	_____	____%	____%	$_____	____%	____%	$_____	yes	no
MIDDLESEX									
Plan A	_____	*__%	*__%	$_____	*__%	*__%	$_____	yes	no
Plan B	_____	____%	____%	$_____	____%	____%	$_____	yes	no
Plan C	_____	____%	____%	$_____	____%	____%	$_____	yes	no
Plan D	_____	____%	____%	$_____	____%	____%	$_____	yes	no
Plan E	_____	____%	____%	$_____	____%	____%	$_____	yes	no
BERGEN									
Plan A	_____	*__%	*__%	$_____	*__%	*__%	$_____	yes	no
Plan B	_____	____%	____%	$_____	____%	____%	$_____	yes	no

Plan C	_____	____%	____% $_____	____%	____% $_____	yes	no
Plan D	_____	____%	____% $_____	____%	____% $_____	yes	no
Plan E	_____	____%	____% $_____	____%	____% $_____	yes	no

*Coinsurance percentages for Plan A are established by rule—no variations are permitted. See Exhibit A of Appendix to N.J.A.C. 11:21.

INOREGS/CM170A

New Rule, R.1995 d.289, effective June 5, 1995.
See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).
Administrative correction.
See: 30 N.J.R. 1047(a).

Repeal and New Rule, R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Section was "SEH Program Premium Comparison Survey".

EXHIBIT GG

Loss Ratio Report Form
New Jersey Small Employer Health Benefits Program
Reporting Year _____
For Preceding Calendar Year Ending December 31, _____

Name of Carrier: _____ NAIC #_____
Address: _____
Check one: Insurance Company _____ HMO _____ Service Plan _____

A separate Report Form shall be completed and filed for each affiliate in addition to a combined report form for affiliated insurance companies or affiliated HMOs. Definitions and instructions regarding words and terms appearing below may be found on the reverse side.

	Total	Standard Plans	Open Non-Standard Plans	Closed Non-Standard Plans	Purchasing Alliance Plans
1. Premiums					
2. Claims (a.+b.–c.+d.–e.) (See definitions, reverse side)					
a.					
b.					
c.					
d.					
e.					
3. Loss Ratio (2./1.)					
4. Dividends (.75 x 1.–2.)*					
5. Dividend Percentage (4.+1.)					

* Note Instruction 4.

I certify that the above information is accurate and complete and has been prepared in accordance with N.J.A.C. 11:21–7A. If Dividends (or credits) are required, an explanation of our plan to issue them is attached.

Actuary's Signature _____ Date _____ Type or Print Actuary's Name _____

Title _____ Telephone Number _____

REPORTING FORM DEFINITIONS AND INSTRUCTIONS

1. "Premiums" are the total earned premiums, on the same earned basis as in the carrier's Annual Statement for the preceding calendar year, before dividends or credits applicable to prior years: (a) combined for all Standard Health Benefits Plans; (b) combined for open Nonstandard Health Benefits Plans; and (c) combined for Closed Nonstandard Health Benefits Plans. Include all Rider Premiums, both Standard and Nonstandard Riders, with the respective Plans which are ridered. The Closed Nonstandard Plans column is for the policies which are renewal only policies continued pursuant to N.J.S.A. 17B:27A–19j(3)(b).

2. "Claims" are equal to:

a. claims paid in the preceding calendar year regardless of the year incurred;

b. plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;

c. less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year (as reported in the preceding year's Loss Ratio Report);

d. plus a residual reserve equal to 3.3 percent of a. + b.–c.;

e. less the residual reserve as reported in the preceding calendar year's Loss Ratio Report.

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

4. "Dividends" are calculated on a combined basis for all standard health benefits plans; for all open nonstandard health benefits plans combined; and for all Closed Nonstandard health benefits plans combined. "Dividends" are equal to 75 percent of the Premiums less Claims (75% of 1. less 2.). (No dividends are required to be paid for nonstandard plans for reporting year 1995.) If the calculated amount is less than zero, then use zero. The Total column should be the sum of the calculated plan columns.

5. "Dividend Percentage" is the percentage ratio of Dividends to Premiums (4. divided by 1.).

Loss Ratio Reports are required to be completed and filed with the Department on or before August 1 of each year for the preceding calendar year, in accordance with N.J.A.C. 11:21-7A. Reports and all required accompanying statements and other information should be sent to the Department at the following address:

Attn: SEH Loss Ratio Report Filings
Life and Health Division
NJ Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

New Rule, R.1996 d.213, effective May 6, 1996.
See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).
Administrative correction.
See: 30 N.J.R. 1047(a).
Amended by R.1998 d.427, effective August 17, 1998.
See: 30 N.J.R. 282(a), 30 N.J.R. 3057(a).
Rewrote the exhibit.
Amended by R.2002 d.342, effective November 4, 2002.
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).
Added a new column "Purchasing Alliance Plans".

EXHIBIT HH

[Carrier] **HMO - POS PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO)
POINT OF SERVICE (POS) CONTRACT

CONTRACTHOLDER: [ABC Company]

GROUP CONTRACT NUMBER
[G-12345]

GOVERNING JURISDICTION
NEW JERSEY

EFFECTIVE DATE OF CONTRACT: [January 1, 2004]

CONTRACT ANNIVERSARIES: [January 1st of each year, beginning in 2005.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February 2004.]

AFFILIATED COMPANIES: [DEF Company]

In consideration of the application for this Contract and the payment of premiums as stated herein, We agree to arrange [or provide] services and supplies and pay benefits 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]

[Include legal name, trade name, phone, fax and e-mail numbers by which consumers may contact the carrier, including at least one toll-free number for [Members]]

TABLE OF CONTENTS

SCHEDULE OF PREMIUM RATES AND CLASSIFICATION

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:

Covered Employee Only ..... $]

[Covered Employee and Spouse..... $