

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.

Source and Effective Date

R.1998 d.512, effective September 25, 1998 and
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).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 21, Small Employer Health Benefits Program, expires on March 23, 2004. See: 35 N.J.R. 4438(a), 35 N.J.R. 5011(a), 36 N.J.R. 145(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 was renamed Non-standard Health Benefits Plans (Filings With the Commissioner): Requirements for Maintaining Nonstandard Plans Subchapter 14 was repealed by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b) 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 as 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: Source and Effective Date. See, also, section annotations.

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APPENDIX. EXHIBITS A THROUGH KK**SUBCHAPTER 1. GENERAL PROVISIONS****11:21-1.1 Purpose and scope**

(a) This chapter implements provisions of P.L. 1992, c.162 as amended by P.L. 1993, c.162, P.L. 1994, c.11, P.L. 1994, c.97, P.L. 1995, c.50, P.L. 1995, c.298, and P.L. 1995, c.340 (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.

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); 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.

“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.

“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.

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).

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 Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004-1109.

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.

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 or HMO, 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.

11:21-7.15 (Reserved)

Recodified to 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).

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.

“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; 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; 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.

“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.

“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.

“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.

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 may result in the carrier losing its authority to write health benefits in New Jersey and imposition of any and all penalties and action available under law.

Amended by R.1993 d.669, effective December 20, 1993.

See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).

11:21-1.5 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).

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. Promulgate one standard claim form. In order to provide a standard system of payment for medical services, all claim forms for any claimant's use under a group health insurance policy delivered or issued for delivery in this State shall conform to the form adopted by the Board and promulgated in conjunction with the Individual Health Coverage Program pursuant to P.L. 1993, c.162, Section 20;

7. 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;

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

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

10. 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;

11. 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.

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

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

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

15. 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.

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. 11:21-2.12.

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 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.

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. Exhibit BB, Part 1 filings received pursuant to N.J.A.C. 11:21-4.2(a), and Exhibit BB, Part 6 filings received pursuant to N.J.A.C. 11:21-3.2(f);

iii. Alternative method of utilization review filings received pursuant to N.J.A.C. 11:21-4.2;

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

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

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

vii. 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.

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.

(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.

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 escrow 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.

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.

(d) For the purpose of disseminating information about the Program, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of member carriers initially shall be based upon the member carriers' addresses filed with the Department pursuant to N.J.A.C. 11:1-25. The Board may proceed to develop its own list of member carriers.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

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).

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 no later than 20 days after receiving the notice of assessment following the procedures in (d) below.

(d) Concurrent with its challenge to the assessment, a carrier shall advise the Board in detail of the reasons why the assessment is inaccurate or not appropriate and shall submit all documentation that supports or tends to support the carrier's position. The carrier shall also advise at this time whether a hearing is requested.

(e) If a hearing is requested, within 45 days of its receipt thereof, the Board shall determine whether the matter constitutes a contested case. If the matter is determined to be a contested case, the Board shall determine whether to hear the matter or refer it to the Office of Administrative Law for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. If the matter does not constitute a contested case, the Board shall review the challenge itself or delegate this review to an appropriate committee to make a recommendation to the Board.

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.

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).

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 coinsurance cap of \$5,000; or

ii. \$750.00 per covered family, to be satisfied on an aggregate basis and a person coinsurance cap of \$5,000.

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

i. \$250.00 per covered person and \$500.00 per covered family; \$500.00 per covered person and \$1,000 per covered family; and \$1,000 per covered person and \$2,000 per covered family. For all three deductible options, the family deductible limit must be satisfied by two separate covered persons. The per person coinsurance caps for Plans B, C, and D are \$3,000, \$2,500, and \$2,000 respectively. The family coinsurance caps for Plans B, C, and D are \$6,000, \$5,000, and \$4,000 respectively, which must be satisfied by two separate covered persons; or

ii. \$250.00 per covered person and \$750.00 per covered family; \$500.00 per covered person and \$1,500 per covered family; and \$1,000 per covered person and \$3,000 per covered family. For all three deductible options, the family deductible limit must be satisfied on an aggregate basis. The per person coinsurance caps for Plans B, C, and D are \$3,000, \$2,500 and \$2,000 respectively. The family coinsurance caps for Plan B, C, and D, are \$9,000, \$7,500, and \$6,000 respectively, which must be satisfied on an aggregate basis.

3. Member carriers may offer Plans B, C and D with the following deductible option, provided that all options offered by the member carrier shall be offered to each small employer:

i. \$2,500 per covered person annual deductible option with \$5,000 annual deductible per covered family where the family deductible limit must be satisfied by two separate covered persons; or

ii. \$2,500 per covered person annual deductible option with \$7,500 annual deductible per covered family where the family deductible limit 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 coinsurance cap of \$1,500, and a family coinsurance cap of \$3,000 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 coinsurance cap of \$1,500, and a family coinsurance cap of \$4,500 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 the following arrangements: \$150.00 hospital inpatient copayment, \$50.00 separate emergency room copayment, \$25.00 pre-natal care office visit copayment (initial visit only) and \$15.00 copayment for all other copayments. Prescription drugs may be subject to 50 percent coinsurance or \$15.00 copayment at HMO member's option. HMO members choosing to offer optional health benefits plans may offer one or more of the following copayment options, provided that all options offered by the HMO member shall be offered to each small employer:

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

2. \$100.00 hospital inpatient copayment, \$50.00 separate emergency room copayment, \$25.00 pre-natal care office visit copayment (initial visit only) and \$10.00 copayment for all other copayments;

3. \$250.00 hospital inpatient copayment excluding mental/nervous and substance abuse, \$200.00 mental/nervous and substance abuse hospital inpatient copayment, \$50.00 separate emergency room copayment, \$25.00 pre-natal care office visit copayment (initial visit only) and \$20.00 copayment for all other copayments;

4. \$300.00 hospital inpatient copayment, \$50.00 separate emergency room copayment, \$25.00 pre-natal care office visit copayment (initial visit only) and a \$30.00 copayment for all other copayments.

(d) The standard health benefits Plans B, C, D and E and optional riders may be offered through or in conjunction with a 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 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 permitted to enter into agreements with participating providers pursuant to any statute. Plans issued through an approved selective contracting arrangement and plans with selective contracting 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;

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.

SUBCHAPTER 5. STANDARD CLAIM FORM

11:21-5.1 Standard claim form

(a) All members offering health benefits plans to small employers, to the extent that the member uses claims forms in its transaction of business (rather than an electronic billing system), shall require as a condition of payment, the standard claim forms approved by the Board and set forth in Exhibit L in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions, set forth in Exhibit L, Part 1, shall be the standard claim form for all medical expenses incurred for services other than hospital inpatient services. The form UB-92 set forth as Exhibit L, Part 2, shall be the standard claim form for all hospital inpatient services.

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

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 reference to electronic billing system and amended UB form reference.

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 120 days prior to the renewal of the small employer's health benefits plan.

11:21-6.3 Enrollment

(a) Small employer carriers shall require each eligible employee electing coverage under the small employer health benefits plan to complete the Enrollment form approved by the Board and specified in Exhibit Q of the Appendix to this chapter incorporated herein by reference, except that carriers can reformat the standard application in any manner necessary to simplify administration for the carrier without modification of the content of the form. At the end of the standard application in an additional section, a carrier may also require periodic updates of the following information: name changes, primary care physician change, health center change, additions or deletions to family coverage, address changes and State and Federal continuation election.

(b) Small employer carriers offering the HMO plan and the HMO POS plan shall require each eligible employee electing coverage under the HMO plan to complete the enrollment form approved by the Board and specified in Exhibit Q of the Appendix to this chapter incorporated herein by reference, except that carriers can reformat the standard application in any manner necessary to simplify administration for the carrier without modification of the content of the form. At the end of the standard application in an additional section, a carrier may also require periodic updates of the following information: name changes, primary care physician change, health center change, additions or deletions to family coverage, address changes and State and Federal continuation election.

(c) A small employer carrier may require a report of an eligible employee's health status for the purpose of determining the applicability of the preexisting condition limitation in accordance with the Act. The carrier shall require eligible employees to complete the Health Status form approved by the Board and specified as optional text in Exhibit Q of the Appendix to this chapter incorporated herein by reference.

1. Such report may be used only for the purpose of determining the applicability of a preexisting condition limitation in accordance with the Act.

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.

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. The waiver form may be combined with Exhibit Q, into a single form, at the option of the carrier without modification of the content of either form, except to reformat in any manner necessary to simplify administration.

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 on or after January 1, 1994.

Amended by R.1994 d.499, effective September 2, 1994.

See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b).

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); 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.

“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 small employer: 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, 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.

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.

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 non-standard 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 geographic location of the small employer, except that small employer carriers that are HMOs may refuse to issue coverage to a small employer not physically located in the HMO’s service area.

2. 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. The small employer carrier may refuse to issue coverage if the participating employees are not physically located within the small employer carrier’s service area, if the small employer carrier is an HMO.

3. 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.

4. 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.

5. 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 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.

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.

11:21-7.4 Restrictions on replacement of health benefits plans

(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.

(d) 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:

1. Refuse to issue a health benefits plan to the small employer group for one year from the last date of coverage of the previous plan; or

2. 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).

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".

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 either:

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

2. Is not covered under the small employer's health benefits plan because the employee is covered as a dependent under a spouse's health benefits policy or contract, as long as the spouse's plan is not an individual health insurance policy or contract but is otherwise included in the definition of creditable coverage.

(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.

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 material in accordance with N.J.A.C. 11:21-6.3 and 6.4; 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.

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 producer, 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.

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) Effective January 1, 1995, a small employer carrier shall file with the Board annually no later than March 15, 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 year, separately as to newly issued plans and renewals, and separately for standard 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 number of health benefits plans in force by geographic territory, labeled A through F, as set forth in N.J.A.C. 11:21-7.14, and by two digit Major Group of the Standard Industrial Classification as of December 31 of the previous calendar year;

3. The number of health benefits plans that were voluntarily cancelled by small employers in the previous calendar year;

4. The number of health benefits plans that were cancelled or nonrenewed by the carrier in the previous calendar year, and the reason for such cancellation or nonrenewal; and

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

(b) 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 standard 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.

(c) Annual and quarterly reports shall be filed at the address listed in N.J.A.C. 11:21-1.3.

(d) 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).

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).

(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:

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.

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).

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.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) A carrier which has been denied non-member certification may contest that determination by filing an appeal with the Board no later than 20 calendar days after receiving the written determination from the Board.

(b) The appeal shall specify the reasons why the Board's determination is inaccurate and shall include all documentation that supports or tends to support the carrier's or entity's position. The carrier or entity also shall specify whether a hearing is requested.

(c) Within 45 days of its receipt of a request for a hearing, the Board shall determine whether bona fide issues of material fact exist such that a hearing shall be conducted. If bona fide factual issues do not exist, the Board shall review the challenge itself and may delegate this review to an appropriate Board committee to make a recommendation to the Board. If a hearing is appropriate, the Board shall determine whether to hear the matter itself or refer it to the Office of Administrative Law for a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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.

(d) If the filing carrier is accepting the nonstandard health benefits plan upon the request of an association, trust or multiple employer arrangement, the filing carrier may amend the nonstandard health benefits plan form to be effective simultaneously with the effective date of the filing carrier's obligations pursuant to any contract transferred to the filing carrier under the nonstandard health benefits plan, subject to the filing carrier filing an amendment made in accordance with N.J.A.C. 11:21-11.7.

(e) If the filing carrier agrees to add a nonstandard health benefits plan to its portfolio at the request of a small employer, the filing carrier shall not amend the nonstandard health benefits plan for six months following the date that the filing carrier's obligations pursuant to the contract issued to the small employer under the nonstandard health benefits plan becomes effective.

1. Any amendment made subsequently shall be made by the filing carrier in accordance with N.J.A.C. 11:21-11.7.

(f) A filing carrier shall not make a request to withdraw a nonstandard health benefits plan that it adds to its portfolio of small employer health benefits plans for at least one 12 month period following the date that the filing carrier's obligations pursuant to contracts issued under the nonstandard health benefits plan first become effective.

New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Former section recodified as N.J.A.C. 11:21-11.10.

11:21-11.9 Additional standards for certifications and standards for review of certifications by the Department

(a) In addition to complying with the other requirements of this subchapter, certifications submitted by carriers in accordance with this subchapter shall comply with the requirements of N.J.A.C. 11:4-40.4, 40.5 and 40.11.

(b) All rate filings shall be submitted as specified in N.J.A.C. 11:21-9.

New Rule, R.1997 d.126, effective March 17, 1997.
See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Former section recodified as N.J.A.C. 11:21-11.11.

11:21-11.10 Informational filing of nonstandard health benefits plans (made in accordance with N.J.S.A. 17B:27A-19j(6)(a) on or before January 31, 1995)

(a) A carrier shall submit a Certification of Prior Filing and Compliance with P.L. 1994, c.11, as set forth in Part 3 of Exhibit BB of the Appendix to this chapter, incorporated herein as part of this subchapter, for all nonstandard health benefits plans continued, renewed or reinstated pursuant to P.L. 1994, c.11, if the carrier has previously submitted the nonstandard health benefits plans to the Commissioner for

filing and the nonstandard health benefits plans were so filed.

(b) A carrier shall submit a Certification of Informational Filing and Compliance with P.L. 1994, c.11, as set forth in Part 4 of Exhibit BB of the Appendix to this chapter, incorporated herein as part of this subchapter, for all nonstandard health benefits plans continued, renewed or reinstated pursuant to P.L. 1994, c.11, if those nonstandard health benefits plans were not previously submitted to the Commissioner for filing.

(c) A certification submitted pursuant to this section shall not be filed by the Commissioner until it is complete.

1. The Commissioner shall notify a carrier when a certification is determined by the Commissioner to be deficient, specifying the reasons therefor in writing.

2. The Commissioner shall determine a certification to be deficient if the certification in any way deviates from the forms as set forth in the Appendix, fails to provide answers to any of the questions contained therein, or the form fails to be certified by a duly authorized officer of the carrier. A certification shall continue to be considered deficient until the carrier submits information satisfactory to the Department to render the certification complete.

3. A carrier shall submit the information necessary to cure any deficiency(ies) or incompleteness specified within 30 days of the date of the notice, or shall become subject to fine.

(d) The completed certification shall include all amendments necessary to bring the nonstandard health benefits plan into compliance with N.J.S.A. 17B:27A-17 et seq. as required by P.L. 1994, c.11. The amendments shall include all necessary language changes, and shall clearly indicate (for ease of reference) all additions and deletions in language necessary for both the nonstandard health benefits plan and any riders and endorsements which may have been issued with or for the nonstandard health benefits plan.

Recodified from 11:21-11.8 and amended by R.1997 d.126, effective March 17, 1997.

See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

Section name changed by adding parenthetical text.

Amended by R.1998 d.533, effective November 16, 1998.

See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

Deleted a former (c); recodified former (d) and (e) as (c) and (d).

11:21-11.11 Penalty and fines

A carrier failing to comply with the requirements of this subchapter shall be subject to payment of a fine not less than \$2,000 nor more than \$5,000 per violation. Except for plans issued through an out-of-State trust, no fine or other penalty shall be assessed against a carrier with nonstandard health benefits plans specified at N.J.A.C. 11:21-11.4 for failure to comply specifically with this subchapter until May 16, 1997, and, with the exception of plans issued through an

out-of-State trust, all carriers with nonstandard health benefits plans as specified at N.J.A.C. 11:21-11.4 shall have the opportunity to come into compliance with this subchapter without penalty by May 16, 1997. This provision shall not effect any penalty or fine made against a carrier prior to the effective date of this subchapter.

Recodified from 11:21-11.9 and 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.

SUBCHAPTER 12. (RESERVED)

SUBCHAPTER 13. NONSTANDARD PLANS: WITHDRAWAL OF PLANS

11:21-13.1 Purpose and scope

(a) This subchapter sets forth the procedures by which a carrier may make a request to withdraw a nonstandard health benefits plan.

(b) This subchapter sets forth standards for review of a request to withdraw a nonstandard health benefits plan.

11:21-13.2 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.

“Closed nonstandard health benefits plan” means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and was reinstated, renewed or continued at the option of the small employer(s) pursuant to N.J.S.A. 17B:27A-19j, but under which contracts or certificates have not been issued or offered on or after January 1, 1994 to a small employer group that was not covered under the health benefits plan prior to January 1, 1994, and which the carrier has certified will not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

The term “closed nonstandard health benefits plan” also means a health benefits plan issued prior to January 1, 1994 that was in effect on February 28, 1994 and reinstated, renewed or continued at the option of a small employer pursuant to N.J.S.A. 17B:27A-19j under which contracts or certificates have been issued subsequent to January 1, 1994 to small employers who were not covered under the health benefits plan prior to January 1, 1994, but under which no such small employers remain covered as of the effective date of this subchapter and which the carrier has certified will not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

“Market,” when used as a verb, means to offer or advertise as available a nonstandard health benefits plan to a small employer for initial purchase or to a small employer who formerly purchased the nonstandard health benefits plan but who is not currently covered under the nonstandard health benefits plan. The term does not include continuation or renewal of a contract, policy or certificate under a nonstandard health benefits plan by a carrier for a small employer currently covered under the nonstandard health benefits plan.

“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 small employers or to one or more employees of a small employer.

“Open nonstandard health benefits plan” means a nonstandard health benefits plan which has been issued or offered to a small employer group that was not covered under the health benefits plan on or before December 31, 1993, or which would otherwise meet the requirements for a closed nonstandard health benefits plan except that the carrier has not certified that the nonstandard health benefits plan will not be offered or issued to any small employer that was not covered under the health benefits plan on December 31, 1993.

“Withdraw” or “withdrawal” means a nonrenewal initiated by a carrier, association, multiple employer arrangement or out-of-State trust of all inforce policies, contracts or certificates issued under a nonstandard health benefits plan.

Amended by R.1998 d.533, effective November 16, 1998.

See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

In “Withdraw” or “withdrawal”, deleted a reference to cancellation.

11:21-13.3 Restricted withdrawal and marketing

(a) A carrier, association, multiple employer arrangement or out-of-State trust shall not withdraw a nonstandard health benefits plan without prior approval of the Commissioner if there was one or more policies or contracts inforce under that nonstandard health benefits plan on December 31, 1993, and one or more small employers continued to be covered under that nonstandard health benefits plan as of January 1, 1994, except as (b) below applies.

(b) A carrier may withdraw a nonstandard health benefits plan without obtaining prior approval pursuant to this subchapter if the carrier is effecting withdrawal from the small employer market in accordance with N.J.A.C. 11:21-16.

1. The carrier shall include in the notice the reasons for the nonrenewal (that is, that withdrawal of the health benefits plan has been approved by the Commissioner pursuant to this subchapter).

2. The carrier shall include in the notice an offer to obtain coverage under the standard health benefits plans issued by the carrier if the policyholder, contractholder, or certificateholder is a small employer (unless the carrier has been granted relief by the Commissioner pursuant to N.J.S.A. 17B:27A–26) or a statement that coverage may be available under an individual health benefits plan if the policyholder, contractholder or certificateholder is not a small employer.

3. The carrier shall include in the notice the name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information concerning the withdrawal.

4. The carrier shall provide notice of the withdrawal to the producer of record for each policy, contract or certificate within 60 days of the date that the request to withdraw is granted.

(b) The withdrawal of the nonstandard health benefits plan shall be completed within 16 months of the date that the request to withdraw is granted.

(c) The nonstandard health benefits plan that is the subject of the request to withdraw shall not be marketed by or through an association, multiple employer arrangement or out-of-State trust to any new small employer from the date that the request to withdraw is granted.

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), substituted “”, and all covered persons and their dependents under the contract or certificate is given 90 days” for “is given 60 days” following “certificateholder” in the introductory paragraph.

11:21–13.7 Other policyholder rights unaffected

Except with respect to a right of guaranteed renewability, nothing in this subchapter shall be construed to contravene any rights of policyholders, contractholders or certificateholders concerning nonrenewal requirements or obligations set forth in a policy or contract of a health benefits plan that is the subject of a request to withdraw.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

Deleted a reference to noncancellation, and substituted a reference to nonrenewal requirements for a reference to cancellation requirements.

SUBCHAPTER 14. (RESERVED)

SUBCHAPTER 15. RELIEF FROM OBLIGATIONS IMPOSED UNDER THE SMALL EMPLOYER HEALTH BENEFITS PROGRAM

11:21–15.1 Purpose and scope

(a) This subchapter establishes the informational and procedural requirements for members requesting relief from

obligations to pay assessments pursuant to N.J.S.A. 17B:27A–38 or to offer coverage or accept applications to a small employer, pursuant to N.J.S.A. 17B:27A–26.

(b) This subchapter applies to all members of the SEH Program.

11:21–15.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A–17 and N.J.A.C. 11:21–1, when used in this subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

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

“Applicant” means the member seeking a deferral of its obligation to pay assessments or a waiver of its obligation to offer coverage and accept applications pursuant to N.J.S.A. 17B:27A–17 et seq.

“Financially impaired” means a member which, after November 5, 1993, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or a member which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

“Relief” means a deferral of obligations pursuant to N.J.S.A. 17B:27A–38 or a waiver of obligations pursuant to N.J.S.A. 17B:27A–26, as applicable.

11:21–15.3 Application procedures and filing format

(a) Any member seeking relief may submit such request to the Department at any time, except that requests for relief from payment of assessments pursuant to N.J.S.A. 17B:27A–38 shall be submitted to the Department no later than 15 days following the due date of payment of the assessment.

(b) All requests outlined in this subchapter shall be accompanied by a statement averring a need for relief from

the obligation(s), as the case may be, including supporting documentation as set forth in N.J.A.C. 11:21-15.4, and shall specify the statutory and regulatory basis for such relief. A single filing may request relief from more than one obligation, but shall specify each obligation from which relief is sought.

(c) Each request shall be in loose leaf form inserted into standard two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in N.J.A.C. 11:21-15.4. The loose leaf sheets used in the request shall be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(d) All members requesting relief pursuant to this subchapter shall submit five copies of each request in the format set forth in (c) above.

(e) If a request fails to materially comply with the filing format and information requirements set forth in N.J.A.C. 11:21-15.4 and this section, the Department shall notify the member that its request for relief is deficient and is denied on such grounds. The notice shall also set forth any information or other action required to cure the deficiency(s). If the member intends to pursue its request, the member shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in this section within 15 days of receipt of the Department's notice of deficiency. Failure to submit within 15 days the information necessary in the proper format to cure the deficiency shall result in the member's request being denied.

(f) All requests for relief or other information required pursuant to this subchapter shall be filed with the Department at the following address:

SEH Program
Request for Relief
New Jersey Department of Banking and Insurance
Division of Financial Solvency
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

Amended by R.1998 d.533, effective November 16, 1998.
Sec: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
In (f), updated address.

11:21-15.4 Informational filing requirements

(a) When requesting relief from obligations pursuant to N.J.S.A. 17B:27A-26b or 17B:27A-38, the applicant shall provide with its request the following information in a clear, concise and complete manner:

1. A cover letter stating:

- i. The name of the applicant;
 - ii. The form of relief and, if a deferral of less than the full amount, specific amount/percentage of relief which the applicant is requesting;
 - iii. A statement of facts relied upon as the basis under which relief is sought, including the specific factor(s) upon which the Commissioner may find that the member is or would be placed in a financially impaired position as set forth in N.J.A.C. 11:2-27.3(a)1 to 29; and
 - iv. The name, title, telephone number and telefax number of a contact person familiar with the filing to whom the Department may direct any additional questions;
2. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation would have on the immediate and long term financial condition of the applicant unless relief is granted as requested;
 3. The most recent financial examination report, whether conducted by the applicant's state of domicile or other state;
 4. A statement addressing whether the applicant is planning to modify its method of doing business in any way including, but not limited to, new acquisitions or new restructuring;
 5. If the applicant is a member of a holding company system, the following shall be provided:
 - i. A list of all members of the holding company system;
 - ii. A list of all intercompany transactions for the period beginning January 1 in the year of the filing to the date of the quarterly statement immediately preceding the date of the filing, in the format set forth in the statutory annual statement filed by the applicant; and
 - iii. A copy of the registration statement filed pursuant to N.J.S.A. 17:27A-3 and the applicant's organizational chart;
 6. An actuarial opinion attesting to the adequacy of reserves specifically for all accident and health lines of business, and for all lines of business which the applicant transacts, in the format of and satisfying all requirements for the actuarial opinion and memorandum required to be submitted as a part of the annual statement filed by the applicant.
 - i. If the applicant is a health maintenance organization, the applicant shall obtain and file an actuarial opinion which complies with the requirements set forth in (a)6 above;

11:21-15.9 Exceptions for health maintenance organizations due to lack of capacity

(a) Any member HMO asserting that it is not required to offer coverage or accept applications pursuant to the requirements of the Act because it reasonably anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, pursuant to N.J.S.A. 17B:27A-26a, shall file the following information with the Commissioner:

1. A cover letter stating:
 - i. The name of the member HMO;
 - ii. A statement that the member is not required to offer coverage or accept applications pursuant to the Act because it anticipates that it will not have the capacity in its network of providers within the service area to deliver service adequately to the members of the additional small employer groups, and the basis for that assertion, with supporting documentation, certified by the president or duly authorized officer of the member; and
 - iii. The number of the member's current individual and group members, listed by provider and classified by the provider's specialty, which shall be updated annually each year the member asserts a waiver pursuant to N.J.S.A. 17B:27A-26a.

(b) The member shall concurrently file the information required pursuant to (a) above with the SEH Program.

(c) Any member HMO denying coverage pursuant to (a) above shall not offer coverage in the small employer market within such service area for a period of at least 180 days after the date that the carrier first denies coverage.

Amended by R.1998 d.533, effective November 16, 1998.
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).
Added (c).

11:21-15.10 Other actions by the Commissioner

Nothing in this subchapter shall be construed as limiting the Commissioner's authority to take such action with respect to insurers, health service corporations, medical service corporations, hospital service corporations or health maintenance organizations as may be authorized by law, including, but not limited to, placing an insurer, health service corporation, medical service corporation, hospital service corporation or health maintenance organization in rehabilitation, liquidation or conservation pursuant to N.J.S.A. 17B:32-31 et seq.

11:21-15.11 Penalties

Failure to comply with this subchapter, including all notice requirements set forth herein, may result in the denial of relief requested and imposition of penalties as authorized by law, including any actions that may be taken by the

Board pursuant to N.J.S.A. 17B:27A-17 et seq. and the SEH Program Plan of Operation, including, but not limited to, imposition of an interest penalty for assessments due from the member and a recommendation by the Board to remove the member's authority to issue any health benefits plans in this State.

SUBCHAPTER 16. WITHDRAWALS OF SMALL EMPLOYER CARRIERS FROM THE SMALL EMPLOYER HEALTH BENEFITS PLANS MARKET

11:21-16.1 Purpose and scope

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers may cease doing business in the small employer market in this State. The subchapter applies to all small employer carriers issuing or renewing policies of contracts after November 30, 1992. Pursuant to the provisions of N.J.S.A. 17B:27A-17 et seq., every policy or contract issued to a small employer in this State shall be renewable with respect to all eligible employees or dependents at the option of the policy or contract-holder or small employer, except under the circumstances prescribed by N.J.S.A. 17B:27A-23 a, c, d, e, f, h, and i. One of the circumstances delineated therein is where a carrier ceases to do business in the small employer health benefits plans market in New Jersey pursuant to N.J.S.A. 17B:27A-23e.

(b) This subchapter applies to all small employer carriers as defined in this subchapter that seek to cease doing business in the small employer market.

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.S.A. reference.

11:21-16.2 Definitions

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

“Affiliate” or “affiliated company” means a carrier that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the carrier that initiates a withdrawal.

“Cease doing business” for purposes of these rules means withdraw or withdrawal.

“Nonstandard health benefits plan” means a health benefits plan policy or contract form under which policies, contracts or certificates 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.

“State” means the State of New Jersey.

“Withdraw” or “withdrawal” means the nonrenewal on the anniversary date of all in force nonstandard health benefits plans or small employer health benefits plans, or both as appropriate, issued to small employers without offering replacement with a small employer health benefits plan (or a nonstandard health benefits plan, if offered through an association, multiple employer arrangement or out-of-State trust that continues to market its nonstandard health benefits plans pursuant to P.L. 1994, c.11), except where such action is taken pursuant to N.J.S.A. 17B:27A-23a, c, d, f, h and i or is approved by the Commissioner in accordance with N.J.A.C. 11:21-11.

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).

In the introductory paragraph, changed N.J.A.C. reference; and in “Withdraw” or “withdrawal”, substituted “nonrenewal” for “cancellation on a date certain or the termination” following “means the”, and changed N.J.S.A. reference.

11:21-16.3 General provisions

(a) No small employer carrier shall nonrenew except in accordance with N.J.S.A. 17B:27A-23a, c, d, f, h and i or refuse to issue any small employer health benefits plan unless the small employer carrier withdraws from the small employer market in New Jersey in accordance with the provisions of this subchapter.

(b) Any small employer carrier which seeks to withdraw from the small employer market in the State shall provide the Commissioner with written notification of its intent to withdraw not later than eight months prior to the nonrenewal on the anniversary date of each in force policy or contract.

1. Until such time as the withdrawal shall be completed, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A-17 et seq. and all rules promulgated thereunder.

2. A withdrawing carrier shall cease issuing new policies no more than two months after filing a notice of intent to withdraw with the Commissioner.

(c) The notice of withdrawal to the Commissioner 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, NJ 08625-0325, and shall include an original and two copies of the following information:

1. The carrier’s percentage market share in the small employer market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;

2. A statement, describing with specificity, the reasons for which the carrier is withdrawing from the small employer market in this State;

3. A statement indicating whether the carrier has any affiliates writing any health lines in this State, the names of such affiliates and the lines of insurance written and a statement indicating whether any such affiliates will continue to write small employer health benefits plans;

4. A statement indicating whether the carrier is withdrawing from other lines of business in this State, and if so, the lines from which it is withdrawing;

5. A statement specifying the date or dates upon which the small employer health benefits plans and nonstandard health benefits plans, as applicable, shall be nonrenewed specifying the date upon which all in force policies or contracts shall begin to be nonrenewed, which shall be the anniversary dates of the policies or contracts of each policyholder;

6. The date upon which the carrier shall cease writing any new nonstandard health benefits plans (if through an association, multiple employer arrangement or out-of-State trust) or small employer health benefits plans, as applicable, which shall be no later than two months after the date the carrier has filed its notice with the Commissioner; and

7. A copy of the form of notice required pursuant to (f) below, which is to be mailed to each affected small employer.

(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;

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; and
4. References to the authority of the Board to take the requested action.

(b) 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.

(c) 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).

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 30 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 pre-proposal 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, 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.

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 law, including, but not limited to, penalties set forth in N.J.S.A. 17B:27A-17 et seq.

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.1999 d.156, effective May 17, 1999.
See: 31 N.J.R. 109(a), 31 N.J.R. 1357(a).

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;

11:21-21.5 Termination of membership in a purchasing alliance

(a) An employer may discontinue purchasing coverage as a member of a purchasing alliance at any time.

(b) A purchasing alliance may include a requirement in its bylaws or joint contract that employers provide no more than 30 days notice of discontinuance to the alliance.

17B:27A-25.1 et seq.). If the Commissioner, after notice and a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., finds that such a violation exists, the premium reduction permitted by N.J.S.A. 17B:27A-25 shall not be applied, and the undiscounted applicable SEH rate shall be applied retroactive to the effective date of the discount.

11:21-21.6 Violations and penalties

(a) Failure to comply with any of the requirements of this subchapter shall be a violation of P.L. 2001, c.225 (N.J.S.A.

APPENDIX

Chapter Appendix Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Exhibits BB, FF and GG, expire on March 23, 2004. See: 35 N.J.R. 4725(a).

EXHIBIT A

[Carrier]

PLAN A

SMALL GROUP HEALTH BENEFITS BASIC POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER: [G-12345]

GOVERNING JURISDICTION: New Jersey

EFFECTIVE DATE OF POLICY: [January 1, 1998]

POLICY ANNIVERSARIES: [January 1st of each year beginning in 1999.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1998.]

AFFILIATED COMPANIES: [DEF Company]

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

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

The Effective Date is specified above.

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

[Secretary President]

[Dividends are apportioned each year.]

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SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN A

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

EXHIBIT H

CARD/MAIL/PRE-APPROVAL/PREFERRED

RIDER FOR PRESCRIPTION DRUG [INSURANCE]

[Policy]holder:
Group Policy No:
Effective Date:

The Prescription Drug Coverage under this Rider [replaces] [supplements] the Prescription Drug coverage specified under the [Policy] to which this Rider is attached when Prescription Drugs are obtained from [either] a [Participating Pharmacy] [or a] [Participating Mail Order Pharmacy].

[Subject to [Carrier] Pre-Approval of certain Prescription Drugs,] [Carrier] cover[s] Prescription Drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only cover[s] drugs which are:

- a) approved for treatment of the [Covered Person's] Illness or Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the [Covered Person's] and recognized as appropriate medical treatment for the [Covered Person's] diagnosis or condition in one or more of the following established reference compendia:
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above Prescription Drugs also includes Medically Necessary and Appropriate services associated with the administration of the Prescription Drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as otherwise stated above.

And [Carrier] exclude[s] drugs that can be bought without a prescription, except for insulin, even if a Practitioner orders them.

DEFINITIONS

Brand Name Drug means:

- a) a Prescription Drug as determined by the Food and Drug Administration; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drug means:

- a) a therapeutically equivalent Prescription Drug, as determined by the Food and Drug Administration;
- b) a drug which is used unless the Practitioner prescribes a Brand Name Drug; and
- c) a drug which is identical to the Brand Name Drug in strength or concentration, dosage form and route of administration.

[Mail Order Program means a program under which a [Covered Person] can obtain Prescription Drugs from:

- a) a Participating Mail Order Pharmacy by ordering the drugs through the mail or
- b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.]

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

[Non-Preferred Drug means a Prescription Drug that is not included on [Carrier's] list of Preferred Drugs.]

[Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is:

- a) equipped to provide Prescription Drugs through the mail; or
- b) is a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.]

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

[Preferred Drug means a Prescription Drug that:

- a) has been designated as such by either [Carrier's] pharmacy and therapeutics committee, or by a third party with which [Carrier] contract[s], as a Preferred Drug;
- b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and
- c) is included on the list of Preferred Drugs distributed to Preferred Providers and made available to [Covered Persons], upon request.

The list of preferred Drugs will be revised, as appropriate.]

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

[PREAPPROVAL REQUIREMENT]

[Carrier] [has/have] identified certain Prescription Drugs for which Pre-Approval is required. [Carrier] will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. [Carrier] will give at least 30 days advance written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

[If a [Covered Person] brings a prescription for a Prescription Drug for which [Carrier] require[s] Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, [the [Covered Person] must contact [Carrier] to request Pre-Approval.] [The Pharmacy will contact the Practitioner to request that the Practitioner contact [Carrier] to secure Pre-Approval.] The Pharmacy will dispense a 96-hour supply of the Prescription Drug. [Carrier] will review the Pre-Approval request within the time period allowed by law. If [Carrier] give[s] Pre-Approval, [Carrier] will notify the Pharmacy, and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of the [Policy]. If [Carrier] do[es] not give Pre-Approval, the [Covered Person] may ask that the Pharmacy dispense the balance of the Prescription Drug, with the [Covered Person] paying for the Prescription Drug. The [Covered Person] may submit a claim for the Prescription Drug, subject to the terms of the [Policy]. The [Covered Person] may appeal a denial by following the Appeals Procedure process set forth in the [Policy].]

COPAYMENT

A [Covered Person] must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a [Participating Pharmacy] [or by a] Participating Mail Order Pharmacy]. The Copayment must be paid before the [Policy] pays any benefit for the Prescription Drug. The Copayment for each prescription or refill [which is not obtained through the Mail Order Program] is:

- for Generic Drugs \$[5.00—\$15] per up to a 30 day supply
- for Brand Name Drugs \$[10.00—\$25] per up to a 30-day supply

[The Copayment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drugs [NONE—\$25] per up to a 90-day supply
- for Brand Name Drugs [\$5.00—\$50] per up to a 90-day supply]]

[Note to carriers—Use the above copayment section if the rider does not include preferred/non-preferred provisions.]

- for Generic Preferred Drugs [\$5.00—\$20]
- for Brand Name Preferred Drugs [\$15.00—\$25]
- for Brand Name Non-Preferred Drugs [\$25.00—\$40]]

[The Copayment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Preferred Drugs [NONE—\$25] per up to a 90-day supply
- for Brand Name Preferred Drugs [\$5.00—\$30] per up to a 90-day supply]
- for Brand Name Non-Preferred Preferred Drugs [\$5.00—\$50] per up to a 90-day supply]

[Note to carriers—Use the above copayment section if the rider does include preferred/non-preferred provisions.]

After the Copayment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy [or by a Participating Mail Order Pharmacy] while the [Covered Person] is [insured]. What [Carrier] pay[s] is subject to all the terms of the [Policy].

[A [Covered Person] and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable copayment for a Preferred Drug. [Carrier] will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

- a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and
- b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the [Covered Person's] Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the [Covered Person].

[Carrier] shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within 5 business days. Denials shall include the clinical reason for the denial. The [Covered Person] may follow the Appeals Procedure set

forth in the [Policy]. In addition, the [Covered Person] may appeal a denial to the Independent Health Care Appeals Program at the Department of Health and Senior Services.]

COVERED DRUGS

The [Policy] only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a [Participating Pharmacy] [or by a [Participating Mail Order Pharmacy]]; and
- c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

- a) [a 90-day supply for each prescription or refill[which is not obtained through the Mail Order Program] where the copayment is calculated based on the multiple of 30-day supplies received;]
- b) [a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the copayment is the copayment specified for a 90-day supply;] and
- c) the amount usually prescribed by the [Covered Person's] Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

[AUDIT PROCEDURES

[Carrier] will arrange for audits that will take place at a time mutually agreeable to the [Participating Pharmacy] [and the] [Participating Mail Order Pharmacy] or the pharmacist and the auditor. The audits shall only include the review of documents relating to persons and prescription plans reimbursable by [Carrier.]]

[Note to carriers: If a carrier elects to include audit procedures in the rider, include your specific audit procedures as an additional paragraph.]

OTHER CHARGES

[Carrier] will not restrict or prohibit, directly or indirectly, a [Participating Pharmacy] [or a] [Participating Mail Order Pharmacy] from charging the [Covered Person] for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the [Covered Person] prior to dispensing the drug.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution—limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the [Covered Person], in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Hospice
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home or similar institution.
- h) Charges for:
 - therapeutic devices or appliances
 - hypodermic needles
 - syringes, except insulin syringes
 - support garments and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental fluorides.

- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a [Covered Person] taking part in a riot or other civil disorder; or the [Covered Person] taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a [Covered Person] while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the [Covered Person's] employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] [is/are] legally required to pay it, [Carrier] will.
- q) Charges for drugs covered under the [Policy] to which this Rider is attached which are covered under the Home Health Care or Hospice Care sections of the [Policy.]
- r) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.
Exception: This Exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

This rider is part of the [Policy]. Except as stated above, nothing in this rider changes or affects any other terms of the [Policy].

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.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.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).
Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).
See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).
Repeal and New Rule, 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).
Section was "Exhibit H: Rider for Prescription Drug Insurance".

EXHIBIT I**SEH-OR-2****RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS**

Policyholder:
Group Policy No:
Effective Date:

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, and Substance Abuse and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only- covers drugs which are:

- a) approved for treatment of the Covered Person's Illness, Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The Mental and Nervous Conditions and Substance Abuse section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and pre-certifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment must be reviewed by [XYZ] before it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

- a) the Medical Necessity and Appropriateness;
- b) the type of service involved;
- c) the appropriate level of care required; and
- d) the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [\$150] for each day of Inpatient care up to a maximum of [\$750] per confinement, subject to a maximum of [\$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [\$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co- Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

- a) days of Inpatient care per Calendar year; and
- b) Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

- a) the Covered Person does not request a review in the times and manner described above;
- b) the Covered Person's treatment does not comply with the treatment plan;
- c) the Covered Person goes to a Provider whose services were not referred by [XYZ]; or
- d) [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].]

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy. [Carrier should insert Standard Rider Closure.]

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.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.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.1998 d.512, effective September 25, 1998.
 See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

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

PART 1

EXPLANATION OF BRACKETS-POLICY AND CERTIFICATE FORMS

(Plans A,B,C,D,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.

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 16 below. Similarly, explicit guidance for the issuance of a Dual Contract POS product is set forth in item 17 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets (HMO Plan), set forth in Part 2 of Exhibit K, 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. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
3. If a Carrier elects to provide for BOTH a family deductible and family Co-Insurance Cap 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 Co-Insurance Cap 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.
4. The refund formula specified on the Premium Amounts provision of the General Provisions may be modified to specify alternate methods of calculation.
5. 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.
6. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
7. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
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. 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.
10. 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. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
11. 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.
12. If the plan being issued is an indemnity plan, Co-Insurance Cap text should be included. If the plan being issued is a PPO or POS plan, Coinsured Charge Limit text should be included.
13. 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.

14. 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, either 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; or the text must be submitted to the Board and the Department of Banking and Insurance for review and approval prior to use, as specified in regulation.
15. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy and certificate, the text must conform to the text of the standard form.
16. 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.
17. 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 uses in conjunction with either the standard \$15 copay plan or one of the optional plans, \$5, \$10, or \$20.
 - b. The Coinsured Charge Limit text that appears on the schedule must be included in lieu of the Coinsurance Cap text. The dollar amount of the Coinsured Charge limit is fixed at \$10,000. There is no family Coinsured Charge Limit in the standard plan design.
 - c. The Benefit Provision of the forms contains language for the Coinsurance Cap and for the Coinsured Charge Limit. Omit the Coinsurance Cap text and include the Coinsured Charge Limit text.
 - d. Carriers may elect to include the appeals procedure that was approved by the State of New Jersey in connection with the filing of the Selective Contracting Arrangement.
 - e. 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.
 - f. If the plan includes utilization review provisions, the penalty provisions must include reference to the fact that the penalty does not count toward the satisfaction of the Coinsured Charge Limit.
17. 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.

While the Coinsured Charge Limit provision is generally used only when plans are issued through or in conjunction with an approved Selective Contracting Arrangement, indemnity plans that are issued as the non-network portion of a Dual Contract POS Plan must include the Coinsured Charge Limit text. That is, include the \$10,000 Coinsured Charge Limit on the Schedule, include Coinsured Charge Limit text in the Benefit Provisions and if UR features are included, refer to the Coinsured Charge Limit in the penalty provisions.

In **addition** to the above items, Carriers must consider the following in connection with the certificate forms:

18. 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.
19. 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.
20. As described in 18 above, variable schedule amounts may be included on the schedule, shown on the face page, sticker or separate schedule.
21. The Payment of Premiums-Grace Period section may be omitted, at the carrier's option.
22. The definition of "You, Your and Yours" may be omitted by carriers that elect to refer to the employee as Employee, rather than in use the personal "You". Throughout the text, the words "You," "Your" and "Yours" must be replaced with "Employee" terminology.

(RIDERS)

All text which is enclosed in brackets [] is variable.

Some areas of variability are self-explanatory. Examples include: [Carrier], [XYZ], and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the rider closure.

The Co-Payment amounts in the Mental and Nervous Conditions and Substance Abuse rider may vary to be consistent with any other Co-Payment amounts allowed for HMO plans.

The appeals Procedure in the Mental and Nervous Conditions and Substance Abuse rider may vary to conform to a carrier's and/or health care review organization's procedure.

PART 2

EXPLANATION OF BRACKETS (HMO PLAN CONTRACT AND EVIDENCE OF COVERAGE)

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.

Note: Explicit guidance for the issuance of a Dual Contract POS product is set forth in item 13 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets Policy Forms set forth in Part 1 of Exhibit K, 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. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
2. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements. 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.
3. The Generic Drug definition can be deleted if not needed.
4. 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.
5. 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.
6. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
7. OB/GYNs can be considered Primary Care Physicians.
8. Eligible class references can be removed.
9. 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. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
10. 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.
11. Small Claims Waiver can be deleted.
12. 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.
13. 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.
14. 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:

14. 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.
15. 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.

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).

**EXHIBIT L
PART 1
PATIENT INSTRUCTIONS
FOR HCFA 1500**

To request reimbursement for medical expenses; please complete the attached form blocks 1 through 13. To assist you, follow the instructions below. Please remember that all statements must be accurate.

Please bring this claim form with you at the time the medical services are rendered. The provider of service is responsible for completing blocks 14 through 33.

When requesting reimbursement, you should also attach copies of itemized bills and receipts for the medical services for which you are submitting a claim.

PATIENT INSTRUCTIONS

Block 1

Place an "X" in the appropriate block which identifies the type of insurance program that applies to the claim.

Block 1a

Enter the Social Security number or unique identification number assigned by the insurance carrier or the individual in whose name the insurance is carried.

Block 2

Enter the patient's last name, first name and middle initial.

Block 3

Enter the patient's date of birth in a MMDDYY format. Example: 01 12 94 for January 12, 1994. Place an "X" in the appropriate gender box.

Block 4

Enter the last name, first name and middle initial of the individual in whose name the insurance is carried.

Block 5

Enter the mailing address of the patient.

Block 6

Place an "X" in the appropriate box which identifies the relationship of the patient to the insured individual.

Block 7

Enter the mailing address of the individual who holds the insurance if it is different from the patient's address listed in Block 5. Otherwise, enter the word "SAME".

Block 8

Place an "X" in the appropriate box which identifies the patient's marital status. Also, place an "X" in the appropriate box which identifies the employment/student status of the patient.

Block 9

If the patient has other insurance, enter the last name, first name and middle initial of the covered individual if it is different from that shown in Block 4. Otherwise, enter the word SAME.

Block 9a

Enter the other insurance carrier's identification number or unique code assigned by the carrier to identify the group or policy under which the individual in Block 9 is covered.

Block 9b

Enter the date of birth of the individual (listed in Block 9) in a MMDDYY format. Example: 011294 for January 12, 1994.

Enter an "X" in the appropriate gender box.

Block 9c

Enter the name of the individual's (listed in Block 9) employer or school name.

Block 9d

Enter the name of the insurance program covering the individual in Block 9.

Block 10a through 10c

Place an "X" in the appropriate box to indicate whether the patient's condition is related to employment, auto accident, or other accident. For auto accidents, indicate the states' abbreviation in which the accident occurred (e.g. New Jersey—NJ).

Block 10d

This field is not required.

Block 11

Enter the identification or unique code assigned by the carrier to identify the group or policy under which the individual is covered.

Block 11a

Enter the individual's (listed in Block 4) birthdate in a MMDDYY format. Example: 011294 represents January 12, 1994.

Place an "X" in the appropriate gender box.

Block 11b

Enter the individual's (listed in Block 4) employer name or school name.

Block 11c

Enter the name of the insurance program covering the individual in Block 4.

Block 11d

Place an "X" in the appropriate box. If the answer is YES, complete sections 9a-9d.

Block 12

The patient's signature in this field authorizes release of medical information necessary to process this claim. The patient or an authorized representative should sign and date this block unless the signature is on file in the provider's office/facility.

Block 13

The signature in this block authorizes the insurance carrier to release insurance benefits directly to the provider of the services listed in Block 33.

Repeal and New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

EXHIBIT M

Carrier:
Group Medical Claims
PO Box XXXXX
Anywhere, New Jersey XXXXX

GE 0094
Annual Family Profile
and Claim Notice

Send this form once each calendar year to the address above with your first claim of the year. If any information changes, send a new one. If you have questions about claims or need forms, call XXX-XXX-XXXX

Employer name	Employer phone number	Plan/Policy Number
Check one <input type="checkbox"/> Active employee <input type="checkbox"/> Retired employee <input type="checkbox"/> Continued individual		

Employee information				
Name	Date of birth	Social Security Number		
Address	City	State	ZIP	Home phone number
Do you have another employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please give name of other employer		Other employer's phone number	
Are you covered by another group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please give name of carrier		Plan number	Other carrier's phone number

Spouse information				
Name	Date of birth	Social Security Number		
Name and address of spouse's employer		Phone number of spouse's employer		
Is spouse covered by another group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please give name of other carrier		Plan number	Other carrier's phone number

Dependent children information					
Name	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Relation to employee	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Relation to employee	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Relation to employee	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Relation to employee	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No

List any additional dependent children on a separate page and attach it to this form. If any child is over the limiting age and a full-time student, please give the information requested below.			
Name	Name of school	Address of school	
Name	Name of school	Address of school	
If any child is covered by another group plan, please give the information requested below.			
Name	Insured person	Name of carrier	Plan number
Name	Insured person	Name of carrier	Plan number

I authorize any provider, insurer, or other organization to release any information regarding the medical history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.		
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a criminal act.		
Signature of employee	Signature of patient if other than minor child	Date

SEH-FP-7/93

EXHIBIT N

[Carrier]

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type Policy number ([Carrier] Use Only)

New Policy Change in Policy Requested Effective Date _____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____

2. Tax Identification Number: _____

3. Main Address: _____ Street City State Zip

Mailing Address: _____ Street City State Zip

Telephone: () _____ Facsimile: () _____

4. Name of Correspondent: _____

5. Type of organization: Corporation Partnership Proprietorship Other (explain): _____

6. Nature of business (specify): _____ SIC Code _____

7. Number of eligible employees in your company: _____ Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number of eligible employees to be insured: _____

9. Class or classes to be excluded: _____

10. Insurance Requested For: Employees Only Employees & Dependents

11. Are you subject to the requirements of COBRA? Yes No

12. Waiting period before employees become insured: (may not exceed 6 months) Present employees: _____ New or Rehired Employees: _____

13. What percentage of the premium will the employer pay? _____

14. Deposit \$ _____ Premium Paid: Monthly Quarterly [Automatic checking withdrawal] Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Table with 3 columns: Legal Name & Location, No. eligible employees in this company, No. eligible employees to be insured. Includes horizontal lines for data entry.

SECTION II: SPECIFICATIONS FOR COVERAGE

[HEALTH BENEFITS

Wraparound (Hospital Base Plan ____ days)

Plan: A B C D E HMO HMO-POS Dual Contract POS

Deductible (Options for plans B, C and D only): (\$250 (\$500 (\$1,000 (\$2,500

High Deductible Options: \$ \$

Co-Payment (Options for HMO Plans Only): \$5 \$10 \$15 \$20 \$30

Managed Care Delivery System: PPO POS None

PRESCRIPTION DRUG BENEFITS

Program Type: Card Mail Order Card/Mail Order

MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Co-Payment Option: \$5 \$10 \$15 \$20

NON-STANDARD OPTIONAL BENEFIT RIDERS]

[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:

- now in force and to be continued? Yes No
- currently being applied for? Yes No

If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)

2. Name of present or prior group carrier: _____

Effective date of prior coverage: _____

Cancellation/termination date: _____

Is the coverage applied for in this application replacing other group insurance?

Yes No

If "Yes" give reason _____

Plan being replaced: A B C D E HMO HMO-POS Dual Contract POS

Other: _____

3. Has your firm been uninsured for 3 or more months prior to application?

Yes No

4. What forms of insurance are now or were in force?

Health Benefits Prescription Drugs (attach copies of Booklet / Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits?

Yes No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?

Yes No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/Extended Benefits	Reason for Termination Disability /Other	Continuation Dates	
				Start	End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:

- a) Are any employees or dependents presently incapacitated? Yes No
- b) Are any dependent children incapable of self-support due to a physical or mental disability? Yes No

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

SECTION IV: AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]

SECTION V: SIGNATURE

[It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.] It is further understood that no agent has power on behalf of [Carrier] to make or modify any request or application for insurance or to bind [Carrier] by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by [Carrier]. [Final rates will be based on enrollment data as of the Policy effective date.] No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date at _____ on _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

For [Carrier]
[Plan] Use
Only

[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[]
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**EXPLANATION OF BRACKETS AND TEXT
APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY**

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.

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).

EXHIBIT O

(1-98)

NEW JERSEY SMALL EMPLOYER CERTIFICATION

For a Group Health Benefits Plan

Employer Name		Group Policy No.		
Address	Street	City	State	Zip

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: Continuee 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							

If additional space is needed, attach a separate sheet.

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162

Group Health Benefits Policy Participation (All Questions Must Be Answered)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for pay . 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 (TEFRA / DEFRA)? Yes No]
 [Is your firm subject to the requirements of COBRA? Yes No]

CERTIFICATION

(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 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 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.

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.

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.

 Signature of Officer, Partner or Owner Title Date

 Print Name of Officer, Partner or Owner

 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 Owner Title Date

 Print Name of Officer, Partner or Owner

 Signature of Witness Date

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).

EXHIBIT P

(RESERVED)

EXHIBIT Q

(1-98)

[Carrier]

SMALL GROUP EMPLOYER BENEFITS ENROLLMENT [AND CHANGE FORM] [AND PRE-EXISTING CONDITIONS STATEMENT]

Please print all information, using ink.

[Policyholder] (full legal name of company): _____ (Policy) No: _____

[Policyholder] Address: _____
 Street City State Zip Code

SECTION I: EMPLOYEE INFORMATION

Name: _____

Last First Middle Initial

Home Address: _____
 Street [Apt.] City [County] State Zip Code

[Telephone: _____
 Home Work

Best place to call during day: ____ Home ____ Work]

Occupation: _____ Title: _____

Date of Employment: _____ Hours worked per week: _____

Are you actively at work? ____ Yes ____ No If "No", explain: _____

Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced

[Are you a resident of the state of New Jersey? ____ Yes ____ No

Do you maintain a residency in another state? ____ Yes ____ No

If "Yes", name the state _____

How much time do you spend there each year? _____]

[REASON FOR COMPLETION OF THIS FORM (please check all appropriate responses)

____ I am an employee of an organization which is applying for coverage

____ I am now eligible for coverage

____ I had no previous coverage during the past 90 days

____ I had previous coverage during the past 90 days.

Name of previous carrier _____ Plan Number: _____

Effective Date: _____ Termination Date: _____

____ I previously refused/waived coverage

____ I am enrolling for coverage during my employer's open enrollment period.

Open Enrollment Date: _____

____ I am continuing under ____ Federal Law (COBRA) or ____ State Law

Qualifying Event: _____ Date Continuation began: _____

Continuation applies to: ____ Employee Only ____ Employee and Eligible Dependents

____ I am continuing under a total disability extension (Attach proof of disability)

____ I am terminating coverage for myself, and all dependents

____ I am adding/deleting dependents

____ Other (Specify): _____]

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within [30] days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within [30] days after the marriage, birth, adoption, or placement for adoption.

SECTION II: COVERAGE INFORMATION

1. Persons to be covered: ____ Employee Only ____ Employee & Child(ren)
 ____ Employee & Spouse ____ Employee, Spouse & Child(ren)

2. Please provide all information for each person to be covered [or deleted].

Full Name (Last, First, Middle Initial)	Add/Delete	Sex	Social Security No.	Birthdate
Employee				
Spouse				
Child				
Child				
Child				
Child				

Attach a separate sheet to list additional children. [Attach proof if full-time student. Attach proof of disability.]

[3. Do any of the dependents listed above live at an address other than the Home address given above?

Yes ____ No ____ If "Yes", name the dependent(s) and provide the address(es)

Explain the circumstances _____

4. If any dependent's last name differs from yours, explain the circumstances _____]

[5. Are any of the dependents listed above confined in a facility or at home, due to a medical reason? ____ Yes ____ No If "Yes", name the dependent(s), and the place and reason for confinement. _____

[6] Indicate whether any person to be covered is enrolled under Medicare, Parts A and/or B.

	Part A	Part B	Medicare ID #
Employee	___ Yes ___ No	___ Yes ___ No	_____
Spouse	___ Yes ___ No	___ Yes ___ No	_____
Child (give name) _____	___ Yes ___ No	___ Yes ___ No	_____

[7] Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury? ____ Auto
____ Medical

[8] Are you, or any person to be covered, eligible for other health coverage? (i.e., employer sponsored group coverage, Medicare, Medicaid) ____ Yes ____ No If "Yes", indicate the name(s) of the person(s), the name(s) of the carrier(s), the policy number(s) and the type(s) of coverage. _____

[9.] Have you, or any dependent(s), as a [Carrier] health plan member, received care at any [Carrier] health care center? ____ Yes ____ No If "Yes", please indicate the medical record number in the space below. If the name of you or your dependent(s) was different at the time of receiving care, please indicate. (ex. maiden name) _____

[10] Are you replacing existing coverage? ____ Yes ____ No If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the names(s) of the persons covered by the policy. _____

[11.] Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? ____ Yes ____ No

If "Yes", attach the Certificate of Group Health Plan Coverage

Please note that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the pre-existing conditions limitation, if applicable.

[SECTION III: CHANGE INFORMATION

[Type of Activity

____ Termination of Employee and Dependent Coverage [Please check reason(s) below]

 Date of Termination _____

____ Add/Remove Dependent

 Reason _____

 Date of Event _____

____ New Telephone Number: (H) _____ (W) _____

____ Change Contract Type from _____ to _____

____ Change Name from _____ to _____

____ Change of PCP, GYN, Health Center (Circle which, state for whom and give new name) _____

____ Withdrawal from Coverage

 Date of Event _____

____ New Address: _____

 Street [Apt.] City [County] State Zip Code]

[Termination Check Reason(s)

____ Deceased ____ Transferred to Other Coverage ____ Dissatisfied with Coverage

____ Ineligible ____ Moved Out of Area ____ Dissatisfied with Medical Care

____ Dissatisfied with Access

Other, please explain: _____

Remarks: _____]]

[SECTION IV: PRE-EXISTING CONDITIONS STATEMENT

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 180 days. This limitation of benefits, services and supplies applies only to employer groups with 2 - 5 employees and to late enrollees. Consult the agent or carrier for information on the waiving of this limitation under circumstances as provided under New Jersey Law.

During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

- | | YES | NO |
|--|-------|-------|
| 1. a. Alcoholism or Drug Abuse | _____ | _____ |
| b. Arthritis | _____ | _____ |
| c. Blood Disorder | _____ | _____ |
| d. Back or Neck Disorder, Injury or Pain | _____ | _____ |
| e. Cancer or Tumors | _____ | _____ |
| f. Diabetes | _____ | _____ |
| g. Gastro or Intestinal Disorder | _____ | _____ |
| h. Heart Disorder or Condition or Chest Pain | _____ | _____ |
| i. High Blood Pressure | _____ | _____ |
| j. Kidney or Liver Disorder | _____ | _____ |
| k. Lung or Respiratory Disorder | _____ | _____ |
| l. Mental or Nervous Disorder | _____ | _____ |
| m. Paralysis, Stroke or Epilepsy | _____ | _____ |

- | | YES | NO |
|--|-------|-------|
| 2. During the past 6 months, have you or any dependent to be covered: | | |
| a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above? | _____ | _____ |
| b. been advised to have treatment or surgery or testing that has not been done? | _____ | _____ |
| c. been admitted to a hospital or other health care facility as an inpatient? | _____ | _____ |
| d. taken prescribed medications? | _____ | _____ |

Please give details of any "YES" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question Name	Condition	Duration of Symptoms, Treatment, Degree of Recovery	Date	Name & Address of Hospitals, Practitioners

[SECTION V: HEALTH CARE SELECTION

Full Name (Last, First, Middle Initial)	[Primary Care Physician]	[Health Care Center]	[GYN]
Employee			
Spouse			
Child			
Child			
Child			
Child			

[NOTE: A Primary Care Physician **must be selected** for each adult member and a Pediatrician must be selected for each child. Women over the age of 16 must also select a GYN.]

[Plan Selection: _____]

SECTION VI: DECLARATION [AND] AUTHORIZATION [AND CONDITIONS OF ACCEPTANCE]

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

- a) the coverage applied for will not take effect unless:
 - after review of this Enrollment Form, [Carrier] accepts it;

- the first premium has been paid to [Carrier]; and
 - I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under for a waiver of the active work requirement.
- b) no person, except an officer of [Carrier] has authority to: determine whether [certificate/evidence of coverage] shall be issued based on this Enrollment Form; waive or modify any of the provisions of the Enrollment Form or any of the [Carrier's] requirements; to bind [Carrier] by any statement or promise pertaining to any [certificate/evidence of coverage] to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.
- c) the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to [Carrier].
- [d [Carrier] does not pay benefits for charges, or provide services or supplies related to a pre-existing condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the pre-existing conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, [Carrier] may pay the health care benefits directly to the provider instead of to me.]

[I state that I am a resident of New Jersey [and I live, reside or work within [Carrier's] service area.]]I understand that if I omit or falsify any statement on this enrollment form, [Carrier] can cancel my coverage as of the original effective date.]

Any person who includes any false or misleading information on an application or enrollment form [and change form] for a health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, [Carrier] will assist the person in obtaining a certificate from the prior plan or issuer.

Conditions of Acceptance

On behalf of myself and the dependents listed on this Enrollment Form, I agree to or with the following:

1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
3. The Contract will determine the rights and responsibilities of [covered persons] [members] [subscribers] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
4. As a condition to [receiving in-network] benefits, employee understands and agrees that (with the exception of emergency procedures as defined in the Contract) all [in-network] services, in order to be covered by [Carrier], must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. [Out-of-network benefits are covered, as stated in the contract.]
5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
6. Employee understands that this coverage will remain in effect regardless of the continued availability of a particular [primary care physician] [health care center][other health care provider].
7. Employee acknowledges that [carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Authorization

1. I authorize the sources stated below to give to [Carrier], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorizes sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [Carrier] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

_____ Date signed

_____ Signature of Employee

_____ Date signed

_____ Signature of Spouse, if providing information on the pre-existing conditions statement

EXHIBIT R

(RESERVED)

Repealed 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).
Exhibit was "Enrollment Application and Change Form".

EXHIBIT S

(RESERVED)

Repealed 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).

Exhibit was "Health Maintenance Organization (HMO) Enrollment Application (and Change Form) Small Employer Health Benefits Plan for Employees and Dependents".

EXHIBIT T

(1-98)

[CARRIER]

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name _____

Employee Name _____ Social Security # _____
Last First MI

Marital Status: ___Single ___Married ___Widowed ___Divorced

Date of Employment _____ Date of Birth _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by [Carrier]. I refuse the following:

___ Employee, Spouse and Child(ren) coverage

___ Spouse coverage

___ Child(ren) coverage

Reason for Refusal (Please check all appropriate lines)

___ other Group Health Plan sponsored by this employer

___ other Group Health Plan sponsored by my spouse's employer

___ other Group Health Plan sponsored by another organization

___ other reasons (please explain) _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s):

Policyholder Name: _____

Carrier: _____

Policy Number: _____

Policyholder Name: _____

Carrier: _____

Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within [30] days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within [30] days after the marriage, birth, adoption, or placement for adoption.

If the reason for refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form [and Pre-Existing Condition Statement], and coverage may be subject to a preexisting conditions exclusion.

Signature of Employee

Date

Signature of Witness

Date

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).

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to \$100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

New Rule, 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.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).

Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).

See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).

Amended by R.2000 d.304, effective June 23, 2000.

See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).

EXHIBIT Z

CARD/MAIL
SEH-OR-EB-1A

RIDER FOR PRESCRIPTION DRUG INSURANCE

[Policyholder:
 Group Policy No:
 Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and

d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is not obtained through the Mail Order Program is:

- for Generic Drugs \$5.00
- for Brand Name Drugs \$10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drugs NONE
- for Brand Name Drugs \$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and
- c) needed to treat an illness or injury.

Such charges will not include charges made for more than:

- a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
- b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
- c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 or similar institution.
- h) Charges for:
 - therapeutic devices or appliances
 - hypodermic needles

- syringes
- support garments
- and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

CARD
SEH-OR-EB-1B

RIDER FOR PRESCRIPTION DRUG INSURANCE

**[Policyholder:
Group Policy No:
Effective Date:]**

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs \$5.00
- for Brand Name Drugs \$10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a. prescribed by a Practitioner (except for insulin)
- b. dispensed by a Participating Pharmacy; and
- c. needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

- a. the greater of a 30 day supply or 100 unit doses; and
- b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center

- an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 - or similar institution.
- h) Charges for:
- therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
- and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

MAIL
SEH-OR-EB-1C

RIDER FOR PRESCRIPTION DRUG INSURANCE

**[Policyholder:
Group Policy No:
Effective Date:]**

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is supplemented with the following:

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs NONE
- for Brand Name Drugs \$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a. prescribed by a Practitioner (except for insulin)
- b. dispensed by a Participating Mail Order Pharmacy for take-home use; and
- c. needed to treat an illness or injury.

Such charges will not include charges made for more than:

- a) a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and
- b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 - or similar institution.
- h) Charges for:
 - therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
 - and other non-medical substances, regardless of their intended use.

- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

SEH-OR-EB-2

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

**[Policyholder:
Group Policy No:
Effective Date:]**

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's Illness, Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution" - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The Mental and Nervous Conditions and Substance Abuse section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and pre-certifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not

comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the Penalty for Non-Compliance with Pre-Certification Requirements section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment must be reviewed by [XYZ] before it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

- a) the Medical Necessity and Appropriateness;
- b) the type of service involved;
- c) the appropriate level of care required; and
- d) the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [\$150] for each day of Inpatient care up to a maximum of [\$750] per confinement, subject to a maximum of [\$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [\$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co- Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

- a) days of Inpatient care per Calendar year; and
- b) Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

- a) the Covered Person does not request a review in the times and manner described above;
- b) the Covered Person's treatment does not comply with the treatment plan;

- c) the Covered Person goes to a Provider whose services were not referred by [XYZ]; or
- d) [XYZ] does not confirm the need for such care or treatment.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or [certificate].

[Carrier should inset Standard Rider Closure.]

CARD/MAIL
SEH-OR-1A

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is not obtained through the Mail Order Program is:

- for Generic Drugs \$5.00
- for Brand Name Drugs \$10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drugs NONE
- for Brand Name Drugs \$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and
- c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

- a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
- b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
- c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home

- a nursing home or similar institution.
- h) Charges for:
 - therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
 and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

CARD
SEH-OR-1B

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs \$5.00
- for Brand Name Drugs \$10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Pharmacy; and
- c) needed to treat an illness or injury.

Such charges will not include charges made for more than:

- a) the greater of a 30 day supply or 100 unit doses; and
- b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital

- a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 - or similar institution.
- h) Charges for:
- therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
 - and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

MAIL
SEH-OR-1C

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:
Group Policy No:
Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is supplemented with the following:

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs NONE
- for Brand Name Drugs \$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Mail Order Pharmacy for take-home use; and
- c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

- a) a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and
- b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing homeor similar institution.
- h) Charges for:
 - therapeutic devices or appliances

- hypodermic needles
 - syringes
 - support garments
- and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
 - j) Charges for drugs for the management of nicotine dependence.
 - k) Charges for topical dental Fluorides.
 - l) Charges for any drug used in connection with baldness.
 - m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
 - n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
 - o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
 - p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
 - q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

SEH-OR-2

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Policyholder:
Group Policy No:
Effective Date:

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, and Substance Abuse and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's Illness, Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

The Mental and Nervous Conditions and Substance Abuse section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and pre-certifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not

comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment must be reviewed by [XYZ] before it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

- a) the Medical Necessity and Appropriateness;
- b) the type of service involved;
- c) the appropriate level of care required; and
- d) the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [\$150] for each day of Inpatient care up to a maximum of [\$750] per confinement, subject to a maximum of [\$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [\$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

- a) days of Inpatient care per Calendar year; and
- b) Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

- a) the Covered Person does not request a review in the times and manner described above;
- b) the Covered Person's treatment does not comply with the treatment plan;
- c) the Covered Person goes to a Provider whose services were not referred by [XYZ]; or

d) [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is no agreement at that time, the Covered Person may appeal directly to [Carrier].]

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.
[Carrier should insert Standard Rider Closure.]

CARD/MAIL
SEH-OR-EB-1A

RIDER FOR PRESCRIPTION DRUG INSURANCE

**[Policyholder:
Group Policy No:
Effective Date:]**

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an illness or injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an inpatient in a facility. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's illness or injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is not obtained through the Mail Order Program is:

- for Generic Drugs \$5.00
- for Brand Name Drugs \$10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drugs NONE
- for Brand Name Drugs \$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and
- c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

- a) the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
- b) a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
- c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital

- a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 - or similar institution.
- h) Charges for:
- therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
- and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

CARD
SEH-OR-EB-1B

RIDER FOR PRESCRIPTION DRUG INSURANCE

[Policyholder:
Group Policy No:
Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

This Rider for Prescription Drug Insurance will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs \$5.00
- for Brand Name Drugs \$10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Pharmacy; and
- c) needed to treat an illness or injury.

Such charges will not include charges made for more than:

- a) the greater of a 30 day supply or 100 unit doses; and
- b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:

- labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
 - d) Charges for refills in excess of that specified by the prescribing Practitioner.
 - e) Charges for refills dispensed after one year from the original date of the prescription.
 - f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
 - g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital
 - a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 - or similar institution.
 - h) Charges for:
 - therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
- and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
 - j) Charges for drugs for the management of nicotine dependence.
 - k) Charges for topical dental Fluorides.
 - l) Charges for any drug used in connection with baldness.
 - m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
 - n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
 - o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
 - p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
 - q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

MAIL
SEH-OR-EB-1C

RIDER FOR PRESCRIPTION DRUG INSURANCE

[Policyholder:
Group Policy No:
Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is supplemented with the following:

This **Rider for Prescription Drug Insurance** will pay benefits for covered drugs, including contraceptive drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

- a) drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
- b) protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

- a) therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
- b) drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
- c) drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

- a) Legend Drugs
- b) compound medications of which at least one ingredient is a Legend Drug;
- c) insulin; and
- d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs NONE
- for Brand Name Drugs \$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

- a) prescribed by a Practitioner (except for insulin)
- b) dispensed by a Participating Mail Order Pharmacy for take-home use; and
- c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

- a) a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and
- b) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

- a) Charges to administer a Prescription Drug.
- b) Charges for:
 - immunization agents
 - biological sera
 - blood or blood plasma.
- c) Charges for a Prescription Drug which is:
 - labeled "Caution - limited by Federal Law to Investigational use"; or
 - experimental.
- d) Charges for refills in excess of that specified by the prescribing Practitioner.
- e) Charges for refills dispensed after one year from the original date of the prescription.
- f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
- g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
 - a Hospital

- a rest home
 - a sanitarium
 - an Extended Care Facility
 - a Substance Abuse Center
 - an alcohol abuse or mental health center
 - a convalescent home
 - a nursing home
 - or similar institution.
- h) Charges for:
- therapeutic devices or appliances
 - hypodermic needles
 - syringes
 - support garments
- and other non-medical substances, regardless of their intended use.
- i) Charges for vitamins, except Legend Drug vitamins.
- j) Charges for drugs for the management of nicotine dependence.
- k) Charges for topical dental Fluorides.
- l) Charges for any drug used in connection with baldness.
- m) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
- n) Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
- o) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
- p) Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
- q) Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

SEH-OR-EB-2

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

**[Policyholder:
Group Policy No:
Effective Date:]**

The Prescription Drug section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, and contraceptive drugs which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

- a) approved for treatment of the Covered Person's Illness, Injury by the Food and Drug Administration;
- b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
 - The American Medical Association Drug Evaluations;
 - The American Hospital Formulary Service Drug Information;
 - The United States Pharmacopeia Drug Information; or
- c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

- a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
- b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

The Mental and Nervous Conditions and Substance Abuse section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and pre-certifies all mental health and Substance Abuse treatment on [Carrier’s] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the Penalty for Non-Compliance with Pre-Certification Requirements section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment must be reviewed by [XYZ] before it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person’s materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

- a) the Medical Necessity and Appropriateness;
- b) the type of service involved;
- c) the appropriate level of care required; and
- d) the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [\$150] for each day of Inpatient care up to a maximum of [\$750] per confinement, subject to a maximum of [\$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [\$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

- a) days of Inpatient care per Calendar year; and
- b) Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

- a) the Covered Person does not request a review in the times and manner described above;
- b) the Covered Person's treatment does not comply with the treatment plan;
- c) the Covered Person goes to a Provider whose services were not referred by [XYZ]; or
- d) [XYZ] does not confirm the need for such care or treatment.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or [certificate].

[Carrier should insert Standard Rider Closure.]

New Rule, 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.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.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.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

Amended by R.1999 d.376, effective October 6, 1999 (operative November 1, 1999).

See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).

Under this section, such [Member] is referred to as a “disabled Medicare eligible”.

This section does not apply to:

- a) a [Member] who is eligible for Medicare by reason of age; or
- b) a [Member] who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A [Member] Becomes Eligible For Medicare

When a [Member] becomes eligible for Medicare by reason of disability, the Contract is the primary plan. Medicare is the secondary plan.

If a [Member] is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of benefits and Services** section of the Contract.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a [Member] who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such [Member] is referred to as a “ESRD Medicare eligible”.

This section does not apply to a [Member] who is eligible for Medicare by reason of disability.

When A [Member] Becomes Eligible For Medicare Due to ESRD

When a [Member] becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which services and supplies are provided or benefits are payable under both the Contract and Medicare, the Contract is considered primary. The Contract provides services and supplies and pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:

- a) the first day of the month during which a regular course of renal dialysis starts; and
- b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such [Member] becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which services and supplies are provided and benefits are payable under both the Contract and Medicare, Medicare is the primary plan. The Contract is the secondary plan. If a [Member] is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **Coordination of benefits and Services** section of the Contract.

[STATEMENT OF ERISA RIGHTS]

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- a) Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the plan administrator’s office and at other specified locations such as worksites and union halls.
- b) Obtain copies of all plan documents and other plan information upon written request to the plan administrator, who may make a reasonable charge for the copies.
- c) Receive a summary of the plan’s annual financial report from the plan administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called “Fiduciaries”, who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee’s claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the plan administrator to provide the materials and pay the Employee, up to \$100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator’s control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan’s money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the plan administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

CLAIMS PROCEDURE FOR [NON-NETWORK] BENEFITS

Claim forms and instructions for filing claims may be obtained from the plan administrator. Completed claim forms and any other required material should be returned to the plan administrator for submission to Us.

We are the Claims Fiduciary with discretionary authority to Determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, We will also observe the procedures listed below. All notifications from Us will be in writing.

- a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after We received the claim.
- b) If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which We expect to render the final decision.
- c) If a claim is denied, We will provide the plan administrator, for delivery to the claimant, a notice that will set forth:
 - the specific reason(s) the claim is denied;
 - specific references to the pertinent plan provision on which the denial is based;
 - a description of any additional material or information needed to make the claim valid. and an explanation of why the material or information is needed;
 - and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

- d) We will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, We will render a decision as soon as possible. but no later than 120 days after receiving the request. We will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.]

New Rule, R.1996 d.199, effective April 15, 1996.

See: 28 N.J.R. 1661(a), 28 N.J.R. 2010(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.299, effective September 1, 1998.

See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(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.1999 d.376, effective October 6, 1999 (operative November 1, 1999).

See: 31 N.J.R. 2442(a), 31 N.J.R. 3340(a).

Amended by R.2000 d.304, effective June 23, 2000.

See: 32 N.J.R. 2210(a), 32 N.J.R. 2592(a).

EXHIBIT JJ

EXPLANATION OF BRACKETS
HMO - POINT OF SERVICE PLAN

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.

Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], [date].

- 1) Some areas of variability are noted with brief explanations within the text.
- 2) Some areas of variability are intended to allow for flexibility in terms of a Carrier's administrative practices.
- 3) Some areas of variability are subject to ranges specified in statute or regulation.
- 4) 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.]

The following explanations apply to the Contract and Evidence of Coverage, unless otherwise stated.

- 1) 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)
- 2) 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)
- 3) 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.
- 4) Copayment, deductible and coinsurance amounts may be elected by the Contractholder, subject to the availability specified in regulation. (Example: "Non-Network options are consistent with the options set forth in Exhibits C and D of the Appendix to N.J.A.C. 11:21.")
- 5) 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.
- 6) 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.
- 7) 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.
- 8) 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.
- 9) 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). (Contract Only). If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
- 10) 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.)
- 11) 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.
- 12) 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.
- 13) 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.
- 14) Carriers may elect to calculate the 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.
- 15) 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.
- 16) The Pre-Existing Conditions exclusion may be omitted.
- 17) 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.
- 18) The "Alternate Treatment Feature" 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.
- 19) The "Centers of Excellence" provision may be omitted. If included in the form, the text must conform to the text of the standard form.
- 20) The "Small Claims Waiver" section of the "Coordination of Benefits" provision may be omitted.
- 21) The refund formula specified in the "Premium Amounts" provision may be modified to specify alternate methods of calculation. (Contract Only)

- 22) 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.
- 23) The "Notice of Loss" section of the "Claims Provisions" may be omitted, at the option of the Carrier.
- 24) The third sentence of the "Payment of Claims" section of the "Claims Provisions" should be omitted, if not applicable.
- 25) Carriers may elect to omit the ERISA provisions.

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.

New Rule, R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(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).

EXHIBIT KK

THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM
CERTIFICATION OF NON-MEMBER STATUS

Carrier Name _____

Address _____

NAIC # _____

I, (print or type name) _____, a duly authorized officer of the above named entity, hereby certify that this entity:

(CHECK EITHER # 1 OR #2)

1. Is not a "carrier" authorized to issue "health benefits plans" in New Jersey, as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17; or

2. Is a carrier that is not a "member" of the New Jersey Small Employer Health Benefits Program because it had no "health benefits plan" in force in 1997 covering a New Jersey "small employer," as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17. The accident and health premiums reported to the New Jersey Department of Banking and Insurance by this carrier for 1997 were entirely attributable to the following types of coverage, all of which are not included in, or are expressly excluded from, the definition of "health benefits plan" in the rule cited above (YOU MUST, IN THE SPACES BELOW, SHOW WHY THE REPORTED A&H PREMIUM IS NOT SUBJECT TO ASSESSMENT IN ORDER FOR THIS CERTIFICATION TO BE APPROVED):

- 1. _____
2. _____
3. _____
4. _____
5. _____

(PLEASE NOTE: CARRIERS THAT COVER NEW JERSEY SMALL EMPLOYERS THROUGH ASSOCIATIONS, TRUSTS, OR MULTIPLE EMPLOYER ARRANGEMENTS ARE MEMBERS OF THE PROGRAM SUBJECT TO ASSESSMENT. IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL (609) 633-1887.

Signature of officer _____ Date _____
Title _____ Telephone Number _____
Fax Number _____

MAIL COMPLETED FORM TO: New Jersey Small Employer Health Benefits Program
PO Box 325
Trenton, NJ 08625-0325

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Administrative correction.

See: 30 N.J.R. 1047(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).