

**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).

**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).

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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## 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.

**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 rule-making, 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.

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## 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;

v. A copy of the nonrenewal notice the carrier shall provide to policyholders or contractholders as described in (c) below;

vi. A copy of the nonrenewal notice the carrier shall provide to producers as described in (d) below; and

vii. A copy of the optional benefit rider the carrier is withdrawing, along with evidence of approval of the rider by the Department or acknowledgment of the rider by the SEH Board.

2. The completed application shall be sent to the following address:

New Jersey Department of Banking and Insurance  
Life and Health Division  
20 West State Street  
PO Box 325  
Trenton, NJ 08625-0325

3. The Department shall review the completed application for compliance with the requirements of this section, and shall provide the carrier within 30 days of receipt with written notice of any deficiencies in the application or with an acknowledgment that the application is complete and in compliance with the requirements of this section.

4. The carrier shall return to the Department an amended application correcting any deficiencies within 30 days of receipt of the Department's deficiency notice.

5. The carrier shall cease issuing the optional benefit rider no later than 60 days after the date that acknowledgment of a complete application to withdraw the optional benefit rider is received.

(c) In addition to meeting all of the other requirements of this subchapter, a carrier seeking to withdraw an optional benefit rider shall provide written notice of nonrenewal of the optional benefit rider to the policyholder or contractholder as follows:

1. An initial notice of nonrenewal shall be provided at least 90 days prior to the anniversary date of the optional benefit rider, and shall include the following:

i. A statement that the carrier has elected to nonrenew the optional benefit rider pursuant to the authority of this subchapter;

ii. A statement that the optional benefit rider shall be nonrenewed on the anniversary date of the rider;

iii. A statement that the carrier shall offer the policyholder the option to purchase any other optional benefit riders that the carrier offers in the small employer market;

iv. A statement that the policyholder or contractholder may contact his or her producer, if any, for additional information regarding the optional benefit rider withdrawal;

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

vi. A statement that in choosing to nonrenew the optional benefit rider and offering all other health insurance the carrier offers in the small employer market, the carrier is acting uniformly without regard to the claims experience of the policyholder or contractholder or to any health status-related factors relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for coverage.

2. In addition to the nonrenewal notice described in (c)1 above, a subsequent notice of nonrenewal shall be included with each monthly premium bill or premium notice issued prior to the date of nonrenewal. If no monthly premium statement is issued, a subsequent notice of nonrenewal shall be provided at least 30 days prior to nonrenewal. The notice shall contain at least the information set forth at (c)1ii and v above.

(d) In addition to meeting all of the other requirements of this subchapter, a carrier seeking to withdraw an optional benefit rider shall provide at least 90 days prior to the anniversary date of the optional benefit rider, a written notice of nonrenewal to the producer of record, if any, for each policy or contract, as follows:

1. The nonrenewal notice to the producer shall include the following:

i. A statement that the carrier has elected to nonrenew the optional benefit rider pursuant to the authority of this subchapter;

ii. The date the optional benefit rider shall be nonrenewed;

iii. A statement that the carrier will offer the policyholder or contractholder the option to purchase all other optional benefit riders that the carrier offers in the small employer market; and

iv. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the optional benefit rider withdrawal.

## SUBCHAPTER 21. SMALL EMPLOYER PURCHASING ALLIANCES

### Authority

N.J.S.A. 17:1-8.1, 17:1-15e, 17B:27A-17 et seq. and 17B:27A-25.9.

### Source and Effective Date

R.2002 d.342 effective November 4, 2002.  
See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).

**11:21-21.1 Purpose and scope**

(a) This subchapter implements P.L. 2001, c.225 by establishing rules for the formation and operation of small employer purchasing alliances.

(b) This subchapter shall apply to eligible groups of small employers as defined in P.L. 1992, c.162 (N.J.S.A. 17B:27A-17).

**11:21-21.2 Definitions**

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

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Department of Banking and Insurance” means the New Jersey Department of Banking and Insurance.

“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.

**11:21-21.3 Filing requirements**

(a) Within 30 days of formation, a small employer purchasing alliance shall file the following with the Commissioner:

1. A certification of an officer or director of the purchasing alliance, which shall include:

- i. The name of the purchasing alliance;
- ii. The members of the purchasing alliance;
- iii. The names of the board of directors, chairman, treasurer and secretary of the purchasing alliance;
- iv. The New Jersey mailing address at which communications for the purchasing alliance are to be received;
- v. The toll free telephone number for prospective members to use to contact the purchasing alliance;
- vi. The eligibility requirements for membership in the purchasing alliance;
- vii. The fees charged to members of the purchasing alliance; and
- viii. A description of the SEH standard plans, and any optional benefit riders, for which the purchasing alliance negotiates or intends to negotiate premiums for its members;

2. A copy of the certificate of incorporation, if any, of the purchasing alliance;

3. A copy of the joint contract executed by all members of the purchasing alliance;

4. A description of the eligible small employers that constitute the purchasing alliance, including their common or similar type of trade or business; the common trade association, professional association or other associations; or common geographic area;

5. A copy of the bylaws of the purchasing alliance, which shall include:

- i. The procedures for the organization and administration of the purchasing alliance; and
- ii. The procedures for the qualification and admission of additional members of the purchasing alliance; and

6. Information about the procedures a small employer should follow to join the purchasing alliance, including a contact person, address, telephone number, and eligibility requirements for membership.

(b) Filings shall be submitted to:

NJ Department of Banking and Insurance  
Att: SEH Rate Filings  
20 West State Street  
PO Box 325  
Trenton, NJ 08625-0325

(c) A current listing of the membership of the purchasing alliance as required by (a)1ii above shall be filed with the Commissioner quarterly. Any other change in the information specified in (a) above shall be filed with the Commissioner within 30 days of the change.

**11:21-21.4 Eligibility requirements**

(a) No purchasing alliance shall use as a basis for exclusion from membership in the alliance any of the following characteristics of any small employer group as a whole, or any person eligible for coverage in that group:

1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of domestic violence;
8. Partial or total disability;
9. Group size;
10. Age;
11. Gender; or
12. Any other health status-related factor.

(b) A purchasing alliance shall not inquire as to the insured or uninsured health care claims experience or cost of any employer or employee.

**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.

**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. 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.

**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: