

**CHAPTER 21**

**SMALL EMPLOYER HEALTH BENEFITS PROGRAM**

**Authority**

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

**Source and Effective Date**

R.1993 d.553, effective October 15, 1993.  
See: 25 N.J.R. 3599(a), 25 N.J.R. 5253(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 21, Small Employer Health Benefits Program, expires on October 15, 1998.

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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.

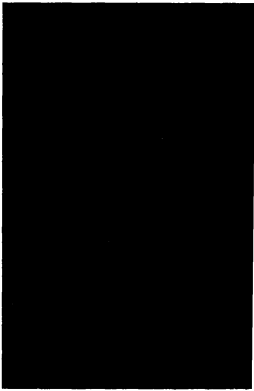
(b) Provisions of the New Jersey Small Employer Health Benefits Act and of this chapter shall be applicable to all carriers that are members of the Small Employer Health Benefits Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(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.



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

7. The small employer carrier institutes a withdrawal in accordance with N.J.S.A. 17B:27A-23e and rules promulgated thereunder by the Commissioner.

(b) Effective January 5, 1996, if a small employer is no longer eligible for coverage, a small employer carrier shall notify a small employer, in writing, at least 60 days prior to the termination of the policy or contract, except if termination is for one of the following:

1. Nonpayment of required premiums by the policy or contract holder or employer;
2. Fraud or misrepresentation of the policy or contract holder or employer; or
3. With respect to coverage of eligible employees or dependents, fraud or misrepresentation of the enrollees or their representatives.

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.

#### 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) Effective on the first fiscal quarter ending on September 30, 1994, 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) In lieu of submission on paper, a small employer carrier is encouraged to submit the reports required by this subsection on a 3.5 inch 1.44 MB computer disk, which provides the information in the format set forth in (a) and (b) above, and includes instructions for the use of the program, which pre-formatted disk is available upon request from the SEH Program at the address listed in N.J.A.C. 11:21-1.3.

(e) 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).

#### 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 on a reasonable and customary standard based on the Prevailing Healthcare Charges System profile for New Jersey, incorporated herein by reference published and available from the Health Insurance Association of America, 1025 Connecticut Avenue, NW, Washington, D.C. 20036-3998.

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.

#### 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

#### Authority

N.J.S.A. 17:1-8.1, 17:1C-6(e) and 17B:27A-25g(2).

#### Source and Effective Date

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 Historical Note

Subchapter 7A, Continuation and Conversion of Existing Contracts, was adopted as R.1993 d.644, effective November 12, 1993. See: 25 N.J.R. 4437(a), 25 N.J.R. 5668(a). Subchapter 7A, Continuation and Conversion of Existing Contracts, was repealed by R.1994 d.499, effective September 2, 1994. See: 26 N.J.R. 3421(a), 26 N.J.R. 4047(b). Subchapter 7A, Loss Ratio-Reports; Dividends and Credits, was adopted by R.1996 d.213, effective May 6, 1996. See: Source and Effective Date.

#### 11:21-7A.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

#### 11:21-7A.2 Definitions

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

“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.

“Total employee months exposed” means the sum of the number of months that each employee was covered during the preceding calendar year. For example, if 40 employees were covered for three months, five employees were covered for 10 months and 12 employees were covered for 12 months, then the total employee months exposed would be 314 ( $\{40 \times 3\} + \{5 \times 10\} + \{12 \times 12\}$ ).

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

(a) Each carrier having the five standard health benefit plan policy forms, non-standard policy forms or HMO plans in force at any time during the preceding calendar year shall file with the Department, for each standard plan including any standard and non-standard riders thereto and for all non-standard plans combined, an annual loss ratio report on the form appearing as Exhibit GG in the Appendix to this chapter, incorporated herein by reference.

(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; except that loss ratio reports for calendar year 1994, including any refund plans, shall be filed no later than June 5, 1996.

(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  
Office of the Life and Health Actuary  
New Jersey Department of Insurance  
20 West State Street  
CN 325  
Trenton, NJ 08625-0325

**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 refunds or credits applicable to prior years, and claims for the preceding calendar year;
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.

**11:21-7A.5 Refund plan**

(a) If the preceding calendar year loss ratio is less than 75 percent, the carrier shall include with 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 policy form 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 the policy form in the preceding calendar year.

(b) Standard plans having total employee months exposed of less than 10,000 shall be combined for refund purposes.

(c) All non-standard plans, regardless of total employee months exposed, shall be combined for refund purposes. Standard plans shall not be combined with non-standard plans.

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

(e) 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 refund by the total premium or on the basis of a practical and equitable alternate methodology filed by the carrier in accordance with (a) above.

(f) All dividends and credits shall be distributed by December 31 of the reporting year; except that refunds based on 1994 experience shall be made no later than 60 days following the Department's approval thereof and shall be limited to the payment of dividends—no credits will be permitted for that year.

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**SUBCHAPTER 8. CARRIER CERTIFICATION OF NON-MEMBER STATUS**
**Authority**

N.J.S.A. 17B:27A-17 et seq., as amended by 17B:27A-51.

**Source and Effective Date**

R.1994 d.228, effective April 11, 1994.  
See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

**11:21-8.1 Purpose and scope**

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

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

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

In (a), deleted reference to "other entities"; and in (b), deleted reference to accident insurance.

### 11:21-8.2 Definitions

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

"Group health benefits plan" means a hospital and medical expense insurance policy, a health service corporation subscriber contract, a hospital service corporation subscriber contract or a health maintenance organization enrollment contract issued to a small employer. A group health benefits plan includes, but is not limited to, a health benefits plan. A group health benefits plan excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, prescription only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers compensation or similar law, automobile medical payment insurance or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.) and stop loss or excess risk insurance.

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State. A State, county or municipal body, agency, board or department shall not be considered a small employer. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer.

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".

### 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 may 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.

### 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 as specified at N.J.A.C. 11:21-1.3.

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

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

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

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

In (a), deleted reference to non-members for calendar year 1993; and in (b), inserted reference to statements required by N.J.A.C. 11:21-8.3.

### 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 30 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.

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

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

### Authority

N.J.S.A. 17:1-8.1, 17:1C-6(e), 17B:27A-25f, and 17B:27A-46.

### Source and Effective Date

R.1994 d.25, effective December 9, 1993.  
See: 25 N.J.R. 5757(a), 26 N.J.R. 245(a).

### 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 the Act.

(b) This subchapter applies to all carriers issuing, renewing, reinstating or continuing health benefits plans to small employers pursuant to the Act.

Amended by R.1994 d.580, effective November 21, 1994.  
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

### 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.

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

"Nonstandard health benefits plan" means a health benefits plan issued prior to January 1, 1994, which was in effect on February 28, 1994, and which has been reinstated, renewed or continued at the option of a small employer pursuant to the requirements of the Act.

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

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

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

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

Amended by R.1994 d.580, effective November 21, 1994.  
See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

### 11:21-9.3 Informational rate filing requirements for health benefits plans renewed between January 1, 1994 and January 1, 1997

(a) All carriers issuing policies, contracts or certificates under standard health benefits plans, including any standard or nonstandard rider option, on or before September 11, 1994, prior to issuing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the following data:

1. A schedule of premiums specifying the standard health benefits plans offered, indicating the delivery system for each plan, describing the benefit differentials for the in-network and out-of-network benefits for selective contracting arrangements and listing the premium rates to be charged;

2. A description of the rating methodology or plan and the numerical value of the classification factors utilized in the calculation of a group's premium rate or rates, including but not limited to: age, gender, industry, geographic location, effective date, and rating categories (for example, standard and substandard) resulting from underwriting rules (for example, medical and non-medical);

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

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

ii. The assumptions used in developing the anticipated loss experience, including trend, plan relativity assumptions and the anticipated distribution of business by rating classification described in (a)2 above and any other factors used; and

iii. If the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A-25g(2), the carrier shall also submit the following:

(1) The assumptions for claim adjudication and payment expense, other administrative expenses, commissions, premium taxes, federal income taxes, risk margin, profit margin and any other margins applicable to the filing;

(2) The assumptions for anticipated investment income; and

(3) The assumptions and the carrier's practices for distributing anticipated divisible surplus including a statement explaining how divisible surplus will be determined and paid; and

4. A certification signed by a member of the American Academy of Actuaries attesting to the accuracy and completeness of the information provided pursuant to (a)1, 2 and 3 above and of the following information which shall also be included:

i. A statement that the filing is complete;

ii. The issue period for which the filed rates are effective, which shall not exceed 12 months;

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

iv. A statement of the anticipated incurred loss ratio for each plan and deductible option which shall not be less than 75 percent of the premium therefor;

v. For rates to be charged for policies, contracts or certificates issued or renewed on and after January 1, 1994 through December 31, 1995, a statement that the rating classification will not produce rates (for an individual and for each family status) for the highest rated group which are greater than 300 percent of rates (for an individual and for each family status) produced for the lowest rated group for each policy form (plan and deductible);

vi. For rates to be charged for policies, contracts or certificates issued or renewed on or after January 1, 1996 through December 31, 1996, a statement that the rating classification will not produce rates (for an individual and for each family status) for the highest rated group which are greater than 200 percent of rates (for an individual and for each family status) produced for the lowest rated group for each policy form (plan and deductible option);

vii. For rates to be charged for policies, contracts or certificates issued or renewed on and after January 1, 1997, a statement that each policy form (plan and deductible option) is community rated for each rating tier (individual, husband/wife, parent/child(ren) and family).

viii. Whether the policies provide that the policyholder will or may receive policyholder dividends other than the dividends required by N.J.S.A. 17B:27A-25g(2); and

ix. A statement that the factors which will be used to establish claim reserves are appropriate.

(b) All carriers issuing or renewing policies, contracts or certificates under a standard health benefits plan, including any standard or nonstandard rider option, after September 11, 1994, prior to issuing or renewing any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the data set forth in (a) above, except that the classification factors utilized in the calculation of a group's premium rate or rates pursuant to (a)4v and vi above shall be limited to age, gender and geography in accordance with N.J.A.C. 11:21-7.15.

(c) All carriers renewing policies, contracts or certificates under a nonstandard health benefits plan (or issuing policies, contracts or certificates under a nonstandard health benefits plan through an association, multiple employer arrangement or out-of-State trust) after September 11, 1994, prior to renewing (or issuing) any policy, contract or certificate under such plan, shall file with the Commissioner an informational rate filing which shall include the data set forth in (a) above, except that the classification factors utilized in the calculation of a group's premium rate or rates pursuant to (a)4v and vi above shall be limited to age, gender and geography in accordance with N.J.A.C. 11:21-7.15.

(d) Any carrier which seeks to change its rates for its health benefits plans shall, prior to the effective date of the revised rates, submit to the Commissioner an informational filing which shall include all of the data set forth in (a) above, except that any change in rates intended to occur after September 11, 1994 shall be filed in compliance with (b) or (c) above, as appropriate.

Amended by R.1994 d.580, effective November 21, 1994.

See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

#### 11:21-9.4 Informational filing procedures

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

Attention: SEH Informational Filings  
 Division of Life/Health Actuarial Services  
 New Jersey Department of Insurance  
 20 West State Street  
 CN 325  
 Trenton, NJ 08625-0325

(b) If the Commissioner determines that an informational filing submitted pursuant to this subchapter is incomplete, the Commissioner shall provide written notice within 30 days to the carrier specifying those portions of the filing which are deficient and the information required to be submitted by the carrier. The notice shall specify whether or not the informational filing is deemed to be in substantial compliance with the requirements of N.J.A.C. 11:21-9.3. If the Commissioner takes no action with respect to the informational filing within 30 days of the date of submission thereof, the informational filing shall be deemed complete.

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

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

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

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

- i. The name, address, and daytime telephone number of a contact person familiar with the matter;
- ii. A copy of the notice involved;
- iii. A statement requesting the hearing; and
- iv. A concise statement specifying the reason(s) the carrier is aggrieved by the Commissioner's determination.

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

Amended by R.1994 d.580, effective November 21, 1994.  
 See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

#### 11:21-9.5 Public disclosure of filed information

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

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

Amended by R.1994 d.580, effective November 21, 1994.  
 See: 26 N.J.R. 3118(a), 26 N.J.R. 4620(a).

#### 11:21-9.6 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of fines or other penalties provided by law, including suspension or revocation of a carrier's authority to do business in the State of New Jersey.

### SUBCHAPTER 10. THE MARKET SHARE REPORT

#### Authority

N.J.S.A. 17B:27A-17 et seq., as amended by 17B:27A-51.

#### Source and Effective Date

R.1994 d.228, effective April 11, 1994.  
 See: 26 N.J.R. 1588(a), 26 N.J.R. 1873(a).

**11:21-10.1 Scope and applicability**

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

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

**11:21-10.2 Definitions**

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

“Group health benefits plan” means a hospital and medical expense insurance policy, a health service corporation subscriber contract, a hospital service corporation subscriber contract or a health maintenance organization enrollment contract issued to a small employer. A group health benefits plan includes, but is not limited to, a health benefits plan. A group health benefits plan excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers compensation or similar law, automobile medical payment insurance or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.)

“Small employer” means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State. A State, county or municipal body, agency, board or department shall not be considered a small employer. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer.

Amended by R.1997 d.62, effective February 3, 1997.  
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).  
Amended “Small employer”.

**11:21-10.3 Filing of the Market Share Report**

(a) Every member of the SEH Program shall file the Market Share Report set forth as Exhibit CC in the Appendix to this chapter, incorporated herein by reference, on or before April 15, 1994 and annually thereafter no later than March 1. Every member shall complete Parts A, B, C, and D of the Market Share Report.

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

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

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

**11:21-10.4 Net earned premium**

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

1. Net earned premium set forth in Part C of the Market Share Report shall include net earned premium resulting from health benefits plans issued, continued or renewed during the preceding calendar year for one or more small employers.

2. Net earned premium reported in Part C of the report form shall be based upon, if not the same as, the data set forth in the member's annual reports, as follows, adjusted to meet the definition of group health benefits plan, as necessary:

i. The NAIC Life and Health Blank (Blue), State page 19, entitled “Accident and Health Insurance,” Column 3 less Column 4, line 23 plus line 23.2 plus line 24.6;

ii. The NAIC Fire and Casualty Blank (Yellow), State page 14 entitled “Exhibit of Premiums and Losses,” Column 3 less Column 4, line 13 plus line 15.1 through line 15.6;

iii. The NAIC HMDI Blank (White), page 6, entitled “Underwriting and Investment Exhibit,” Part 1, line 5, Column 9 less (Column 2 minus Column 3), and less reinsurance portions of (Column 5 minus Column 8);

iv. The New Jersey State HMO Annual Statement (for 1992 and 1993, if elected), page 32 Report # 2, Current Year Lines 1 plus 2 plus 4 plus 5; or

v. The NAIC HMO Blank (for 1993, if elected, and 1994 thereafter), page 4, Report # 2, Column 2, lines 1 plus 2 plus 3 plus 4.



Title

Telephone Number

## REPORTING FORM DEFINITIONS AND INSTRUCTIONS

1. "Premiums" are the total earned premiums, on the same earned basis as in the carrier's Annual Statement for the preceding calendar year, before refunds or credits applicable to prior years, for each Standard Plan separately, and for Non-Standard Plans as a whole. Include all Rider Premiums, both Standard and Non-Standard Riders, with the respective Plans which are ridered. The Non-Standard Plans column is for the policies which are renewal only policies continued pursuant to N.J.S.A. 17B:27A-19j.

2. "Claims" are equal to

- a. claims paid in the preceding calendar year regardless of the year incurred;
- b. plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;
- c. less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year (as reported in the preceding calendar year's Loss Ratio Report);
- d. plus a residential reserve equal to 3.3 percent of a. through c. above;
- e. less the residual reserve as reported in the preceding calendar year's Loss Ratio Report.

3. "Loss Ratio" is the quotient, to the nearest .1 percent, of the Claims divided by the Premiums (2. divided by 1.).

4. "Total Employee Months Exposed" is defined as the sum of the number of months that each employee was covered during the year. For example, if 40 employees were covered for 3 months, 5 employees were covered for 10 months and 12 employees were covered for 12 months, then the Total Employee Months Exposed would be  $314 \{ (40 \times 3) + (5 \times 10) + (12 \times 12) \}$ .

5. "Dividends" are calculated for each standard plan whose Total Employee Months Exposed is equal to 10,000 or more; on a combined basis for all standard plans whose Total Employee Months Exposed is less than 10,000; and for the non-standard plans as a whole. "Dividends" are equal to 75 percent of the Premiums less Claims (75% of 1. less 2.). (No dividends are required to be paid for non-standard plans for reporting year 1995.)

6. "Dividend Percentage" is the percentage ratio of Dividends to Premiums (5. divided by 1.).

Loss Ratio Reports are required to be completed and filed with the Department on or before August 1 of each year for the preceding calendar year. Reports should be sent to the Department at the following address:

Attention: SEH Loss Ratio Report Filings  
Office of the Life & Health Actuary  
New Jersey Department of Insurance  
20 West State Street  
PO BOX 325  
Trenton, NJ 08625-0325

New Rule, R.1996 d.213, effective May 6, 1996.  
 See: 28 N.J.R. 59(a), 28 N.J.R. 234(b), 28 N.J.R. 2388(a).  
 Administrative correction.  
 See: 30 N.J.R. 1047(a).

**EXHIBIT HH**

[Carrier] **HMO - POS PLAN**

**SMALL GROUP HEALTH MAINTENANCE ORGANIZATION  
 POINT OF SERVICE CONTRACT**

**CONTRACTHOLDER:** [ABC Company]  
**GROUP CONTRACT NUMBER** [G-12345] **GOVERNING JURISDICTION** NEW JERSEY

**EFFECTIVE DATE OF CONTRACT:** [January 1, 1998]

**CONTRACT 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]

In consideration of the application for this Contract and the payment of premiums as stated herein, We agree to arrange [or provide] services and supplies and pay benefits in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

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

The Effective Date is specified above.

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

[Secretary President]

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**SCHEDULE OF PREMIUM RATES AND CLASSIFICATION**

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:

- Covered Employee Only ..... \$ ]
- [Covered Employee and Spouse ..... \$
- Covered Employee and Child(ren)..... \$
- Covered Employee and Family ..... \$  
 (including Covered Employee, spouse and one or more eligible dependents)]

We have the right to change any Premium rate(s) set forth above at the times and in the manner established by the provision of this Contract entitled **General Provisions**.

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

**CLASS**  
 [All eligible employees]

**OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)**

<b>[NETWORK]</b>	
Copayment	[\$15], unless otherwise stated
Emergency Room Copayment	\$50, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0% [except as stated on the Schedule of Covered Services and Covered Supplies]

<b>[NON-NETWORK]</b>	
<b>Calendar year Cash Deductible (All Cause)</b>	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	[\$250, \$500, or \$1000]
Per Covered Family	[\$500, \$1,000 or \$2,000. NOTE: Must be individually satisfied by 2 separate [Members]]
	[\$750, \$1500, or \$3000]
 Emergency Room Copayment (waived if admitted within 24 hours)	 \$50
 Coinsurance	 [30%, 20%] [ except as stated below]
<b>Exception: For charges for Mental and Nervous Conditions and Substance Abuse treatment</b>	 25%
 Coinsured Charge Limit	 \$10,000

**MAXIMUM LIFETIME BENEFITS**

[NETWORK]	Unlimited, except as otherwise stated
[NON-NETWORK]	\$5,000,000 per [Member], except as otherwise stated

**SCHEDULE OF COVERED SERVICES AND SUPPLIES AND COVERED CHARGES**

**THE SERVICES, SUPPLIES AND BENEFITS COVERED UNDER THIS CONTRACT ARE SUBJECT TO THE PAYMENT OF THE APPLICABLE COPAYMENTS, DEDUCTIBLE AND COINSURANCE.**

<b>SERVICES</b>	<b>[NETWORK]</b>	<b>[NON-NETWORK]</b>
Hospital		