

**CHAPTER 21**

**SMALL EMPLOYER HEALTH BENEFITS PROGRAM**

**Authority**

N.J.S.A. 17:1-8.1, 17:1-15e, and 17B:27A-17 et seq.;  
and P.L. 2007, c. 345 and P.L. 2008, c. 38.

**Source and Effective Date**

R.2009 d.277 and d.278, effective August 18, 2009.  
See: 41 N.J.R. 84(a), 41 N.J.R. 1147(a),  
41 N.J.R. 3444(a), 41 N.J.R. 3451(a).

**Chapter Expiration Date**

In accordance with N.J.S.A. 52:14B-5.1.c(2), Chapter 21, Small Employer Health Benefits Program, Subchapters 1 through 3, 4 through 7, 10, 17, 18, and 23, and Appendix Exhibits D, F, G, K, T, W, Y, BB, CC, DD, HH, and II, expire on February 14, 2017. See: 48 N.J.R. 1564(a).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 21, Small Employer Health Benefits Program, Subchapters 7A, 9, 11, 13, 15, 16, 19, 20, and 21, and Appendix Exhibits BB Parts 3 through 5, FF, and GG, expire on August 18, 2016. See: 43 N.J.R. 1203(a).

**Chapter Historical Note**

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

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

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

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

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

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

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

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

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

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

Subchapter 11, Nonstandard Health Benefits Plan Filings With the Commissioner: Form Filings and Request to Withdraw Plan Forms, was renamed Nonstandard Health Benefits Plans (Filings With the Commis-

sioner): Requirements for Maintaining Nonstandard Plans, and Subchapter 14, Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status, was repealed by R.1997 d.126, effective March 17, 1997. See: 28 N.J.R. 4364(a), 29 N.J.R. 887(b).

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

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

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

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

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

Subchapter 20, Withdrawals of Standard SEH Plan Optional Benefit Riders, was adopted as R.1999 d.156, effective May 17, 1999. See: 31 N.J.R. 109(a), 31 N.J.R. 1357(a).

Subchapters 1, 2, 3, 4, 5, 6, 7, 8, 10, 17, 18, 23 and Appendix Exhibits H, N, O, T, CC, DD, and KK were readopted as R.2004 d.107, effective February 19, 2004. Subchapters 7A, 9, 11, 13, 15, 16, 19 and Appendix Exhibits BB, FF, and GG, were readopted as R.2004 d.108, effective February 19, 2004. As part of R.2004, d.107, Subchapter 5, Standard Claim Form, was repealed effective March 15, 2004. See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a); 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).

Subchapter 20, Withdrawals of Standard SEH Plan Optional Benefit Riders, was readopted as R.2004 d.149, effective March 18, 2004. See: 36 N.J.R. 145(a), 36 N.J.R. 1942(a).

Subchapter 3A, Non-Standard Health Benefits Plans, expired on February 19, 2009.

Chapter 21, Small Employer Health Benefits Program, Subchapters 7A, 9, 11, 13, 15, 16, 19, 20 and 21, and Appendix Exhibits BB Parts 3 through 5, FF, and GG, were readopted as R.2009 d.277, effective August 18, 2009. See: Source and Effective Date. See, also, section annotations.

Chapter 21, Small Employer Health Benefits Program, Subchapters 1 through 3, 4 through 7, 8, 10, 17, 18, 23, and Appendix Exhibits A, D, F, G, H, K, N, O, T, V, W, Y, BB Parts 1, 2 and 6, CC, DD, HH, II and KK, were readopted as R.2009 d.278, effective August 18, 2009. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 21, Small Employer Health Benefits Program, Subchapters 1 through 3, 4 through 7, 10, 17, 18, and 23, and Appendix Exhibits D, F, G, K, T, W, Y, BB, CC, DD, HH, and II, were scheduled to expire on August 18, 2016. See: 43 N.J.R. 1203(a).

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## SUBCHAPTER 1. GENERAL PROVISIONS

## 11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended (N.J.S.A. 17B:27A-17 et seq.), herein referred to as the Small Employer Health Benefits Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-17 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Small Employer Health Benefits Program pursuant to N.J.S.A. 17B:27A-17 et seq.

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

(c) Provisions of the New Jersey Small Employer Health Benefits Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

Petition for Rulemaking: Exhibit G.

See: 26 N.J.R. 2488(b), 26 N.J.R. 3089(a), 26 N.J.R. 3758(a).

Petition for Rulemaking: Exhibit G.

See: 26 N.J.R. 5120(a), 27 N.J.R. 1321(b).

Petition for Rulemaking: Exhibits A through G.

See: 26 N.J.R. 5120(c), 27 N.J.R. 946(c).

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

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

Inserted additional P.L. references.

Amended by R.2004 d.107, effective March 15, 2004.

See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

In (a), deleted references to P.L. 1993, 1994, and 1995 in the first sentence.

## 11:21-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

“Act” means P.L. 1992, c.162, as adopted and subsequently amended (N.J.S.A. 17B:27A-17 et seq.), also referred to herein as the Small Employer Health Benefits Act.

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

“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.

“Allowed charge” means an amount that is not more than the lesser of the allowance for the service or supply as determined by the standard approved by the Board as set forth at N.J.A.C. 11:21-7.13 or the negotiated fee schedule.

“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.

“Carrier coinsurance” means the percentage of a covered charge paid by a 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.

“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.

“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.

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

“Dependent” means the spouse or child of an eligible employee subject to applicable terms of the employee’s health benefits plan. The reference to “spouse” includes a civil union partner pursuant to P.L. 2006, c. 103, and same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage, except that spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended. At the option of the small employer, “spouse” includes a domestic partner pursuant to P.L. 2003, c.246.

“Eligible employee” means a full-time, bona fide employee who works a normal work week of 25 or more hours. The term excludes a sole proprietor, a partner of a partnership, or an independent contractor and 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.

“Employee” as used in paragraph 2 of the definition in this section of “small employer” means an individual who is an employee under the common law standard as described in 26 CFR 31.3401(c)-1. Employee excludes a sole proprietor, a partner in a partnership, and more than a two percent shareholder in a Subchapter S corporation as well as immediate family members of such individuals. Employee also excludes a leased employee.

“Employee open enrollment period” means the 30-day period each year designated by the small employer during which:

1. Employees and dependents who are eligible under the small employer’s plan but who are late enrollees may enroll for coverage under the small employer’s plan; and
2. Employees and dependents who are covered under the small employer’s plan may elect coverage under a different policy, if any, offered by the small employer.

“Employer open enrollment period” means the period from November 15 through December 15 each year beginning in 2014.

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

upon which that member's market share allocation of assessments shall be calculated by the Board.

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

**11:21-11.1 Purpose and scope**

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

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

renew, and may amend and which may be moved from one carrier to another by a small employer or an association, out-of-State trust and multiple employer arrangement subject to the approval of the Commissioner.

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

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

Amended by R.1997 d.126, effective March 17, 1997.

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

Substantially amended section.

**11:21-11.2 Definitions**

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

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

“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 shall 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 shall 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 for initial purchase by small employers 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 shall not be offered for issue to any small employer that was not covered under the health benefits plan on December 31, 1993.

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

In introductory paragraph, substituted reference to N.J.A.C. 17B:27A-17 for reference to the Act; added “Benefits coverage”, “Closed nonstandard health benefits plan”, and “Open nonstandard health benefits plan”; deleted “Substantial threat to a carrier’s financial condition” and “Withdrawal”; and amended “Market” and “Nonstandard health benefits plan”.

### 11:21-11.3 General standards for continuing and renewing a nonstandard health benefits plan

(a) A carrier shall continue and renew a nonstandard health benefits plan in accordance with this subchapter unless the carrier has:

1. Filed a request to withdraw the nonstandard health benefits plan in accordance with the requirements of N.J.A.C. 11:21-13, and the request has been approved by the Commissioner; or
2. The carrier has filed a notice of withdrawal from the small employer market in accordance with the requirements of N.J.A.C. 11:21-16 and N.J.S.A. 17B:27A-23e.

(b) Renewal of a nonstandard health benefits plan shall be provided at the request of a small employer that is covered by the nonstandard health benefits plan issued by the carrier at the time that the request is made.

1. A request made by a small employer that was covered by the nonstandard health benefits plan issued by the carrier, but who is not so covered at the time that the request is made, shall not be deemed a request for renewal.
2. A request made of a carrier by a small employer to renew a nonstandard health benefits plan issued by and in force under another carrier at the time the request is made shall not be deemed a request for renewal.

(c) Notwithstanding (b) above, a carrier shall not be required to renew a nonstandard health benefits plan under the following circumstances:

1. Nonpayment or payment beyond expiration of the grace period, if any, of the required premium by the policyholder, contractholder or employer;
2. The policyholder, contractholder 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;

3. The small employer fails to meet either the participation or contribution requirements;

4. In the case of nonstandard health benefits plans issued to or through an association, trust or other multiple employer arrangement, for a small employer if the small employer ceases to be a member of the association, trust or other multiple employer arrangement but only if such coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual;

5. The small employer has decided to cease offering and to nonrenew a particular type of nonstandard health benefits plan in the small employer market, or as permitted or required pursuant to N.J.S.A. 17B:27A-19; or

6. In the case of a health maintenance organization plan issued to a small employer, an eligible person no longer resides, lives or works in the carrier's approved service area, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; or a small employer 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.

(d) In the event that a small employer is being nonrenewed pursuant to (c)4 above, the carrier shall provide notice to the small employer that the same standard health benefits plan(s) available to the small employer through the association, trust or other multiple employer arrangement are available from the carrier directly along with the other standard health benefits plans and rider options that the carrier offers to other small employers.

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

Section was "Restricted withdrawal and marketing".  
Amended by R.1998 d.533, effective November 16, 1998.  
See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

In (c), inserted "or payment beyond expiration of the grace period, if any," following "Nonpayment" in 1, rewrote 2, added "but only if such coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual" at the end of 4, and added 5 and 6.

#### 11:21-11.4 Certification of benefits coverage and actuarial value of nonstandard health benefits plans

(a) For nonstandard health benefits plans for which the carrier made an informational filing of a Certification of Prior Filing and Compliance with P.L. 1994, c.11, set forth as Part 3 of Exhibit BB in the Appendix to this chapter, on or before January 20, 1995 in accordance with N.J.A.C. 11:21-11.9, or made an informational filing of a Certification of Informational Filing and Compliance with P.L. 1994, c.11, as set forth as Part 4 of Exhibit BB in the Appendix to this chapter, on or before January 31, 1995 in accordance with N.J.A.C. 11:21-11.9, carriers shall file the nonstandard health benefits plan accompanied by a completed Checklist and Certification as set forth in Part 5 of Exhibit BB in the

Appendix to this chapter, incorporated herein as part of this subchapter.

(b) Each such filing shall comply with N.J.A.C. 11:4-40, except that only one copy of the forms need be submitted. The forms submission shall include the nonstandard health benefits plan form, the form of all riders offered therewith, and the application for the nonstandard health benefits plan.

(c) Separate checklists and certifications and certified statements as set forth in Part 5 of Exhibit BB of the Appendix to this chapter shall be submitted for each nonstandard health benefits plan.

(d) A checklist and certification and statement certified to by an officer of the carrier submitted pursuant to this section shall not be accepted by the Commissioner until it is complete.

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

Section was "Request to withdraw nonstandard health benefits plans".

#### 11:21-11.5 Closed books of business

(a) A carrier seeking approval to treat a nonstandard health benefits plan as a closed nonstandard health benefits plan shall specify that on the Checklist and Certification required to be filed for that nonstandard health benefits plan pursuant to N.J.A.C. 11:21-11.4.

(b) Notwithstanding that a nonstandard health benefits plan may meet the definition of a closed nonstandard health benefits plan, if the carrier does not specify that the nonstandard health benefits plan is closed as set forth in (a) above, the carrier shall not treat the nonstandard health benefits plan as a closed nonstandard health benefits plan at any time in the future.

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

Section was "Review and approval of a request to withdraw".

#### 11:21-11.6 Obligation to market

(a) Except with respect to nonstandard health benefits plans for which the carrier has filed a statement in accordance with N.J.A.C. 11:21-11.5, the carrier shall market the nonstandard health benefits plan to all small employers, their eligible employees and their eligible employees' dependents, as appropriate, within an association, out-of-State trust or other multiple employer arrangement, with all options and riders until such time as the carrier withdraws the nonstandard health benefits plan pursuant to N.J.A.C. 11:21-13, the carrier withdraws from the small employer market pursuant to N.J.A.C. 11:21-16, or, in the case of an association, the association terminates its sponsorship or endorsement of the nonstandard health benefits plan.

1. The obligation to market a nonstandard health benefits plan exists only with respect to an association's, trust's or other multiple employer arrangement's small employers, the small employers' eligible employees and the eligible employees' dependents, as appropriate; a carrier shall not newly issue a nonstandard health benefits plan to any other association, out-of-State trust or multiple employer arrangement (that will be offered to small employer members or participants of the association, multiple employer arrangement or out-of-State trust) except as N.J.A.C. 11:21-11.8 may apply.

2. The carrier shall similarly market every nonstandard health benefits plan that the carrier agrees to add to its portfolio in accordance with N.J.A.C. 11:21-11.8 at the request of a small employer or association, out-of-State trust or multiple employer arrangement.

(b) With respect to nonstandard health benefits plans offered by or through an association, multiple employer arrangement or out-of-State trust, the small employers of the association, multiple employer arrangement or out-of-State trust shall be offered one or more standard health benefits plans through the association, multiple employer arrangement or out-of-State trust, among which shall be Plan C.

(c) No carrier shall be relieved of its obligation to market all of the standard health benefits plans by virtue of marketing at least one standard health benefits plan through an association, multiple employer arrangement or out-of-State trust.

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

Section was "Standards for the process of withdrawal of a nonstandard health benefits plan either by cancellation or nonrenewal".

#### 11:21-11.7 Amendments

(a) A carrier may amend a nonstandard health benefits plan that has been approved or deemed approved by the Commissioner by submitting for approval the amendment together with a new, completed Checklist and Certification set forth in Part 5 of Exhibit BB of the Appendix to this chapter.

1. Each such filing shall comply with N.J.A.C. 11:4-40, except that only one copy of the form(s) need be submitted.

2. The carrier shall submit a separate Checklist and Certification for each nonstandard health benefits plan form being amended, clearly identifying the nonstandard health benefits plan form, and the date(s) previous certification(s) made in compliance with this subchapter were filed.

3. The carrier shall certify on the Checklist and Certification, for each plan being amended that the amendment to the nonstandard health benefits plan does not reduce the actuarial value or the benefits coverage of the nonstandard health benefits plan below the benefits coverage of Plan A and the actuarial value of the standard health benefits plan with the lowest actuarial value of the standard health benefits plans created by the Board.

4. The carrier simultaneously shall submit an explanation of the manner in which the amendment to the nonstandard health benefits plan affects the premiums for the health benefits plan, in accordance with N.J.A.C. 11:21-8.

(b) Notwithstanding (a) above, a carrier shall not amend a nonstandard health benefits plan for six months following the date that the first contract or policy under the nonstandard health benefits plan becomes effective with that carrier if the carrier agreed to add the nonstandard health benefits plan to its portfolio at the request of a small employer pursuant to N.J.S.A. 17B:27A-19j(12) and N.J.A.C. 11:21-11.8.

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

Section was "Other policyholder rights unaffected".

#### 11:21-11.8 Agreement by a carrier to add a nonstandard health benefits plan to its portfolio

(a) A carrier may agree to add a nonstandard health benefits plan not currently being offered by the carrier to its portfolio of small employer health benefits plans at the request of either an association, multiple employer arrangement, trust or a single small employer if that nonstandard health benefits plan has been renewed by the current carrier in accordance with this subchapter and upon the new carrier filing the nonstandard health benefits plan with the Commissioner in accordance with N.J.A.C. 11:4-40 and submission of a completed Checklist and Certification as set forth in Part 5 of Exhibit BB of the Appendix to this chapter.

(b) The filing carrier simultaneously shall comply with N.J.A.C. 11:21-11.6, with initial date of marketing of the nonstandard health benefits plan specified in writing by the filing carrier, which date shall be no later than the effective date of the filing carrier's obligations pursuant to any contract transferred to the filing carrier under the nonstandard health benefits plan.

(c) Upon written request by the Department, the carrier currently marketing the nonstandard health benefits plan shall submit to the Department in writing for each nonstandard health benefits plan form being accepted by a filing carrier the current carrier's identification of the nonstandard health benefits plan form, and the date(s) the current carrier's checklists and certification(s) with appropriate statements made in compliance with this subchapter for the nonstandard health benefits plan form(s) were filed by the Department (including amendments thereto, if any).

(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**

Pursuant to N.J.S.A. 17B:27A-43, a carrier failing to comply with the requirements of this subchapter shall be subject to payment of a fine of not less than \$2,000 nor more than \$5,000 per violation.

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.  
Amended by R.2004 d.108, effective March 15, 2004.  
See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).  
Rewrote the section.

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## SUBCHAPTER 12. (RESERVED)

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## 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.

(c) A carrier shall market all open nonstandard health benefits plans made available through an association, trust or other multiple employer arrangement to all small employers members within that association, trust or other multiple employer arrangement, and the employees of such small employers.

(d) A carrier shall not market a closed nonstandard health benefits plan either directly or through an association, out-of-State trust or multiple employer arrangement.

(e) An association, multiple employer arrangement or out-of-State trust may market an open nonstandard health benefits plan, but if it does market an open nonstandard health benefits plan to its members' employees and dependents it shall offer coverage to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust, and in no instance shall actual or expected health status be used in determining membership.

1. An association, multiple employer arrangement or out-of-State trust that markets an open nonstandard health benefits plan shall also market at least one standard health benefits plan in accordance with N.J.A.C. 11:21-11.6.

2. In no instance shall a closed nonstandard health benefits plan be marketed.

3. No carrier shall be relieved of its obligation to market all of the standard health benefits plans by virtue of marketing at least one standard health benefits plan through an association, multiple employer arrangement or out-of-State trust.

#### 11:21-13.4 Request to withdraw nonstandard health benefits plans

(a) A carrier may submit to the Commissioner a completed request to withdraw one or more closed and open nonstandard health benefits plan(s) at any time except that a carrier shall not:

1. Submit more than one request to withdraw at any one time, but may amend its request to withdraw, if necessary;

2. Submit a request to withdraw a nonstandard health benefits plan that the carrier added to its portfolio of health benefits plans in accordance with N.J.A.C. 11:21-11.8 within the first 12 month period following the effective date of the carrier's obligation pursuant to contracts issued under that nonstandard health benefits plan; or

3. Submit a request to withdraw while a request for relief pursuant to N.J.A.C. 11:20-11 or 11:21-15 is pending.

(b) A carrier may submit a single filing to request withdrawal of more than one closed and open nonstandard

health benefits plans, but shall clearly specify each nonstandard health benefits plan for which a withdrawal is sought, with separate proofs of unreasonable financial burden submitted for each nonstandard health benefits plan.

(c) A carrier shall submit five copies of each request to withdraw in loose leaf form, inserted into two-ring or three-ring binders, tabbed or otherwise indexed to correspond to the exhibits set forth below.

1. A cover letter stating:

i. The name of the carrier, and 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;

ii. A clear specification of the nonstandard health benefits plan(s) which the carrier is seeking to withdraw, including the market name(s), form number(s), and the date(s) the form filing(s) was (were) approved by the Department; and

iii. A statement of facts relied upon as the basis under which the request is sought, including the specific factor(s) upon which the Commissioner may find that maintaining the nonstandard health benefits plan(s) represents an unreasonable financial burden to the carrier;

2. If the carrier intends to establish that renewal of an open nonstandard health benefits plan is an unreasonable financial burden for the carrier, then the carrier shall provide the following:

i. A statement certified to by an officer of the carrier that the total number of lives eligible for small employer health benefits plans covered under the open nonstandard health benefits plan during the 12 month period immediately preceding the date of submission of the request to withdraw was 1,000 or fewer, including only employees and not dependents; or a demonstration that the actual loss ratio of the open nonstandard health benefits plan is 100 percent, or greater, for the 12 month period preceding the date of submission of the request to withdraw;

ii. A detailed explanation, with supporting documentation, of the projected effect that continuation of the nonstandard health benefits plan(s) would have on the immediate and long term financial condition of the carrier;

iii. The most recent financial examination report, whether conducted by the carrier's state of domicile or other state;

iv. A statement addressing whether the carrier is planning to modify its method of doing business in any way, including, but not limited to, new acquisitions or new restructuring;

v. Three-year financial projections beginning with the calendar year of the date of the filing assuming both that the request to withdraw is granted and that it is denied;

vi. A description of any relief from obligations imposed by this State or any other state granted or in effect within the preceding 12 months, and the basis upon which such relief was granted; and

vii. Any other information the Commissioner may specifically deem relevant to the consideration of the particular carrier's request.

(d) The request to withdraw shall be accompanied by the form of the notice of nonrenewal to be provided to policyholders, contractholders, and certificateholders, which notice shall be in compliance with N.J.A.C. 11:21-13.6(a).

(e) Carriers requesting to withdraw a nonstandard health benefits plan shall concurrently provide notice of the request to the SEH Program at the address specified at N.J.A.C. 11:21-1.3.

(f) At the time of the filing of the request to withdraw, the carrier shall specify the number of policies, contracts and certificates issued under each nonstandard health benefits plan that is the subject of the request to withdraw, the approximate number of lives covered under each such nonstandard health benefits plan, and the approximate number of small employers covered under each such nonstandard health benefits plan.

(g) Carriers submitting a request to withdraw shall submit that request to:

SEH Program  
Request to Withdraw Nonstandard Plans  
Life and Health Division  
New Jersey Department of Banking and Insurance  
PO Box 325  
Trenton, NJ 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 (g), changed Division reference.

#### 11:21-13.5 Review and approval of a request to withdraw

(a) The Department shall deny a request to withdraw if the request fails to substantially comply with the filing format and information requirements set forth in N.J.A.C. 11:21-13.4. The Department shall notify the carrier in writing that its request to withdraw is deficient on such grounds. If the carrier intends to pursue its request to withdraw, the carrier shall submit the additional information specified or otherwise submit a filing in accordance with the format requirements specified in N.J.A.C. 11:21-13.4 within 30 days of receipt of the Department's notice of deficiency. Failure to submit within 30 days the required information shall result in the carrier's request being denied without prejudice.

(b) When the Commissioner determines that the requirement to continue servicing the nonstandard health benefits plan(s) specified in the request to withdraw is an unreasonable financial burden for the carrier, the Commissioner shall notify the carrier in writing that it may withdraw the specified nonstandard health benefits plan(s) subject to the standards of N.J.A.C. 11:21-13.6.

(c) If the Commissioner denies a carrier's request to withdraw made pursuant to the provisions of N.J.A.C. 11:21-13.4, the carrier may request a hearing on the Commissioner's determination within seven days from the date of receipt of such determination as follows:

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

- i. The name, address, and daytime telephone number of a contact person familiar with the matter;
- ii. A copy of the Commissioner's determination;
- iii. A statement requesting a hearing; and
- iv. A statement describing in detail the basis for which the carrier believes that the Commissioner's denial is erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the carrier and such personnel of the Department as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

3. The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

i. In a matter which has been determined to be a contested case, if the Commissioner finds that there are no good-faith disputed issues of material fact and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition on the matter.

ii. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

#### 11:21-13.6 Standards for the process of withdrawal of a nonstandard health benefits plan

(a) Carriers shall effect the withdrawal of the specified nonstandard health benefits plan(s), if the request is granted by the Commissioner, through nonrenewal of the policies, contracts or certificates issued under the nonstandard health benefits plan(s) at the time of the 12-month anniversary date of each such policy, contract or certificate, provided that each policyholder, contractholder or certificateholder, and all covered persons and their dependents under the contract or certificate is given 90 days written notice prior to the date of the nonrenewal.

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(ies). 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.  
See: 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;

corrected and the petition may be resubmitted for further consideration.

(d) Any document submitted to the Board which is not in substantial compliance with (a) above shall not be deemed to be a petition for a rule requiring further Board action pursuant to N.J.S.A. 52:14B-4(f).

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

In (a), added 5; added a new (b) and recodified former (b) and (c) as (c) and (d).

### 11:21-18.3 Procedure of the Board

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:21-18.2 the Board shall, within 15 days, file a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;
2. The substance or nature of the rulemaking action which is requested;
3. The problem or purpose which is the subject of the request; and
4. The date the petition was received.

(b) Within 60 days of receiving a petition in compliance with N.J.A.C. 11:21-18.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;
2. The New Jersey Register citation for the notice of petition, if that notice appeared in a previous New Jersey Register;
3. Certification by the Board that the petition was duly considered pursuant to law;
4. The nature or substance of the Board's action upon the petition; and
5. A brief statement of reasons for the Board's action.

(c) Board's action on a petition may include:

1. Denying the petition;
2. Filing a notice of proposed rule or a notice of 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 25, 1998.

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

In (a), inserted “, within 15 days,” following “shall” in the introductory paragraph.

Amended by R.2004 d.107, effective March 15, 2004.

See: 35 N.J.R. 5011(a), 36 N.J.R. 1594(a).

In (b), substituted “60” for “30” in the introductory paragraph.

## SUBCHAPTER 19. SEH PROGRAM PREMIUM COMPARISON SURVEY

### 11:21-19.1 Purpose and scope

(a) This subchapter requires the annual submission of data by small employer carriers to the Department, and establishes the format for the submission of such data, regarding premiums charged for the five standard health benefits plans, the HMO plan, the HMO/POS plan, and any standard rider packages established by the Board, so that the Department may develop and publish an annual SEH Program Premium Comparison Survey, pursuant to N.J.S.A. 17B:27A-33g.

(b) This subchapter shall apply to all small employer carriers.

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

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

In (a), inserted a reference to HMO/POS plans.

### 11:21-19.2 Definitions

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

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

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

### 11:21-19.3 SEH Program premium comparison survey

(a) Every small employer carrier shall prepare and file with the Department a premium survey reflecting premiums charged for each of the five standard small employer health benefits plans, the HMO plan, the HMO/POS plan, and for any standard rider packages, as set forth in Exhibit FF of the Appendix to this chapter, incorporated herein by reference.

(b) Every small employer carrier shall complete the survey in the format set forth in Exhibit FF in accordance with the instructions set forth therein, and shall not vary the information solicited in Exhibit FF.

(c) Completed survey forms shall be filed no later than November 1 of each year, and shall reflect the monthly premiums to be charged for each of the standard health

benefits plans, the HMO plans and the HMO/POS plans 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  
Life & Health Division  
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.

Amended by R.2009 d.277, effective September 21, 2009.

See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).

In (c), deleted "five" preceding "standard", and substituted "and" for a comma preceding and deleted ", and any standard rider packages" following "the HMO/POS plans"; and in the address in (e), substituted "Life & Health Division" for "Public Affairs Office".

#### 11:21-19.4 Penalties

Failure to comply with the requirements of this subchapter may result in the imposition of penalties as authorized by N.J.S.A. 17B:27A-43.

Amended by R.2004 d.108, effective March 15, 2004.

See: 35 N.J.R. 4438(a), 36 N.J.R. 1605(a).

Amended the N.J.S.A. reference.

### SUBCHAPTER 20. WITHDRAWALS OF STANDARD SEH PLAN OPTIONAL BENEFIT RIDERS

#### 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 and 17B:27A-17 et seq.

### Source and Effective Date

R.2004 d.149, effective March 18, 2004.  
See: 36 N.J.R. 145(a), 36 N.J.R. 1942(a).

### Subchapter Historical Note

Subchapter 21, Small Employer Purchasing Alliances, was adopted as R.2002 d.342, effective November 4, 2002. See: 34 N.J.R. 1310(a), 34 N.J.R. 3857(a).

Subchapter 21, Small Employer Purchasing Alliances, was readopted as R.2004 d.149, effective March 18, 2004. See: Source and Effective Date.

### 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.

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**SUBCHAPTER 22. (RESERVED)**


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**SUBCHAPTER 23. RULEMAKING; PUBLIC NOTICES; INTERESTED PARTIES MAILING LIST**
**11:21-23.1 Purpose and scope**

(a) The purpose of this subchapter is to establish the procedures that the Board uses in providing notice of proposed rulemaking, receiving public comments regarding existing rules and proposed rulemaking, extending the public comment period, conducting a public hearing, and providing notice of public meetings.

(b) This subchapter shall apply to all rulemaking of the Board.

**11:21-23.2 Public notice regarding proposed rulemaking**

(a) Unless the Board proposes a rule pursuant to the special procedures set forth at N.J.S.A. 17B:27A-51, the Board shall provide for the following four types of public notice for rule proposals in accord with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30:

1. The rule proposal shall be filed with the Office of Administrative Law for publication in the New Jersey Register;

2. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the

substance of the proposed rulemaking, shall be posted and made available electronically on the Department of Banking and Insurance website at: <http://www.njdoibi.org>;

3. The news media maintaining a press office in the State House Complex shall be provided notice of the rule proposal, as posted and made available electronically on the New Jersey Department of Banking and Insurance website; and

4. The notice of the rule proposal, as filed with the Office of Administrative Law, or a statement of the substance of the proposed rulemaking, shall be made available to the Board's list of "interested persons" by e-mail or hard copy. Interested persons are those who have informed the Board in writing that they wish to receive notice of the Board's proposed regulations, as well as those people or entities that the Board determines are the subject of or significantly related to the rulemaking so that the persons most likely to be affected by or interested in the intended action receive notice.

**11:21-23.3 Extension of the public comment period**

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may extend the time for submission of public comments on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, shall extend the time for submission of public comments for an additional 30-day period, if, within 30 days of the publication of a notice of proposal, sufficient public interest is demonstrated in an extension of time to submit comments.

(c) The Board shall determine that a sufficient public interest for the purpose of extending the public comment period has been demonstrated if any of the following has occurred:

1. Comments received indicated a previously unrecognized impact on a regulated entity or persons; or

2. Comments received raise unanticipated issues related to the notice of proposal.

**11:21-23.4 Conducting a public hearing**

(a) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30, may conduct a public hearing on a proposed rulemaking, at its discretion, without the need for a specific request or the demonstration of sufficient public interest.

(b) The Board, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Office of Administrative Law Rules for Agency Rule-making, N.J.A.C. 1:30, shall conduct a public hearing if sufficient public interest has been demonstrated.

(c) A person interested in having a public hearing held on a notice of proposal shall submit an application within 30 days following the publication of the notice of proposal in the New Jersey Register in a form prescribed by the Board, to the Executive Director at the address listed in N.J.A.C. 11:21-1.3. The application shall contain the following information:

1. The person's name, address, telephone number, agency or association (if applicable);
2. The citation and title of the proposed rule and the date the notice of proposal was published in the New Jersey Register; and
3. The reasons a public hearing regarding the notice of proposal is considered necessary pursuant to (d) below.

(d) The Board shall determine that a sufficient public interest has been demonstrated for the purpose of holding a public hearing if the application demonstrates that additional data, findings and/or analysis regarding the notice of proposal are necessary for the Board to review prior to adoption of the proposal in order to ensure that the notice of proposal does not violate the intent of the statutory law.

#### 11:21-23.5 Public notice regarding board meetings

(a) The Board shall adopt an annual schedule of regular meetings to be held by it the following calendar year.

(b) The Board may schedule meetings in addition to those set forth in the annual schedule.

(c) The Board shall provide public notice for all meetings by:

1. Posting of a notice at the office of the Secretary of State;
2. Posting of a notice at the office of the Board at the address set forth at N.J.A.C. 11:21-1.3;

3. Posting of a notice on the Department of Banking and Insurance website at: <http://www.njdobi.org>;

4. Posting of the notice in two newspapers of general circulation designated by the Board; and

5. Mailing, either by hard copy or electronically, of the notice to a distribution list of those persons who have requested in writing to be informed of the Board's meeting schedule.

#### 11:21-23.6 Board mailing list of interested parties

(a) For the purpose of disseminating information about the SEH Program, including information about rulemaking and meeting dates, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of members shall be based upon the member carriers' addresses filed with its most recently filed Exhibit CC Market Share Report.

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 mailing 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, other than copies of proposals, from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

**EXHIBIT BB**

**PART 2**

**CERTIFICATION OF PROMOTIONAL AND MARKETING MATERIAL**

Submit this form pursuant to N.J.A.C. 11:21-17.3 by March 1 of every year to the SEH Board at the address specified at N.J.A.C. 11:21-1.3 and to the Division of Life and Health Actuaries, New Jersey Department of Banking and Insurance, 20 W. State Street, CN-325, Trenton, NJ 08625-0325, Attn: SEH Promotional and Marketing Certification.

Carrier's Name: \_\_\_\_\_ NAIC #: \_\_\_\_\_

Respondent's Name: \_\_\_\_\_

Respondent's Title \_\_\_\_\_

Respondent's Address: \_\_\_\_\_

Respondent's Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Respondent's Email: \_\_\_\_\_

I, the undersigned, hereby certify that the promotional and marketing material to be disseminated regarding the small employer health benefits plans, including all terms definitions and text, are consistent with N.J.S.A. 17B:27A-17 et seq. and N.J.A.C. 11:21.

I certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

\_\_\_\_\_  
Date Signature (No stamps)

Printed Name

\_\_\_\_\_  
Title

PART 3  
CERTIFICATION OF PRIOR FILING AND COMPLIANCE WITH P.L. 1994,  
C.11

In accordance with N.J.A.C. 11:21-11.8(a), submit this form to the SEH Board at the address specified at N.J.A.C. 11:21-1.3 and in triplicate to the New Jersey Department of Insurance as follows: Attn: Nonstandard Plan Compliance (SEH), Division of Life and Health Actuarial Services, N.J. Department of Insurance, 20 West State Street, CN-325, Trenton, NJ 08625-0325.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier's Name: \_\_\_\_\_  
NAIC #: \_\_\_\_\_  
Respondent's Name: \_\_\_\_\_  
Respondent's Title: \_\_\_\_\_  
Respondent's Address: \_\_\_\_\_

Respondent's Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

2. NONSTANDARD HEALTH BENEFITS PLAN INFORMATION (Submit the requested information with respect to one nonstandard health benefits plan form only. Use "NA" to indicate when a question or request is not applicable.)

- a. Form identification number: \_\_\_\_\_
- b. Form's market name: \_\_\_\_\_
- c. Date filed (approved) by the Commissioner: \_\_\_\_\_
- d. Specify which of the following have been approved with respect to this form, providing the most recent date that an approval was received for each:

Form amendment: \_\_\_\_\_  
Rider form: \_\_\_\_\_  
Endorsement form: \_\_\_\_\_

- e. Has this nonstandard health benefits plan been marketed and sold by or through an association, multiple employer arrangement and/or out-of-state trust?  
\_\_\_\_ Yes \_\_\_\_ No

If yes, please specify the name(s) of the association, multiple employer arrangement and out-of-state trust and the number of policyholders or certificateholders constituting groups of 49 or fewer lives (including single lives) in each association, multiple employer arrangement or out-of-state trust:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ Check here if additional pages are attached.

- f. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, will this nonstandard health benefits plan continue to be marketed and sold to new small employer members of the association, multiple employer arrangement and/or out-of-state trust?  
\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ NA

- g. If marketed and sold through an association, multiple employer arrangement and/or out-of-state trust, is this the only manner by

EXHIBIT FF

STATE OF NEW JERSEY  
SEH PROGRAM PREMIUM COMPARISON SURVEY

Submit this completed survey no later than December 1 of each year to:

Life and Health Actuarial  
Premium Comparison Survey  
P.O. Box 325  
20 West State Street  
Trenton, NJ 08625-0325

or

Fax to: 609-633-0527  
Attn: Neil Vance  
or E-mail: [neil.vance@dobi.state.nj.us](mailto:neil.vance@dobi.state.nj.us)  
with copy to: [avnee.parekh@dobi.state.nj.us](mailto:avnee.parekh@dobi.state.nj.us)

NOTE: Use PO Box for US Mail, Street Address for UPS/FedEx or other express services

Part 1

COMPANY AND RESPONDENT INFORMATION

Company Name:	
NAIC #:	
Respondent's Name:	
Respondent's Title:	
Respondent's Address:	
Respondent's Telephone:	
Respondent's Facsimile:	
Respondent's Email:	

CERTIFICATION

I certify that the information set forth in this SEH Premium Comparison Survey is true and accurate, and hereby further certify that I am authorized to execute this certification on behalf of the above-named carrier.

Respondent's Name:	
Respondent's Signature:	
Date Submitted:	

Part 2

TOLL-FREE INFORMATION

Company's toll-free number where employers may obtain premium quotes:	
Company's email address to which employers may direct inquiries:	
Company's web address where employers may obtain plan information:	

Part 3

DIRECTIONS FOR COMPLETING THE PREMIUM SURVEY

- A. Give monthly premium, rounded to the nearest dollar, for a standard policy issued on **the next** January 1 to an employer described in paragraph C below, for each plan in accordance with paragraph D below. The following abbreviations and instructions apply:
- SCA: Selective Contracting Arrangement (An arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations (see N.J.A.C. 11:4-37.2)) offered in conjunction with Plan(s) B, C, D, or E.
  - POS: A standard HMO Point of Service Plan (HMO/POS plan) (N.J.A.C. 11:21-3.1(h)) or standard non-HMO Point of Service Plan (POS plan) (N.J.A.C. 11:21-3.1(g)).

- Standard Premium: The standard plan is offered or purchased without optional riders. **This premium must include all standard benefits, including standard prescription drug (Rx) benefits, and must not reflect any non-standard riders which increase or decrease benefits. The standard Rx plan for any plan other than an in-network only HMO plan is Rx covered subject to the indemnity or out-of-network cost sharing.**

- Rx: For HMO (in-network-only) Plan, the standard Rx benefit is 50%. (Pursuant to N.J.A.C. 11:21-3.1(c)3iii carriers are allowed the option of a \$15 copay, but this option does not appear to be used.)

B. Use “NA” to indicate when any plan variation is not being offered.

C. For purposes of completing the survey, assume the policyholder is a small employer, located in one of the following counties: Bergen, Camden, and Middlesex, with six employees as follows:

1. Single Female - age 27
2. Single Male - age 37
3. Female Parent - age 47, with two children
4. Male Employee and Spouse - both age 57
5. Male Employee - age 27; Spouse - age 24; two children - both under age 18
6. Female Employee - age 47; Spouse - age 50; two children - both under age 18

D. Follow instruction on Page 10 to describe all delivery systems

E. If any of plans A - E are available on both an Indemnity and PPO (or POS) basis, give a PPO (or POS) premium on that Plan Page. If plans C or D are available on both a PPO and POS basis, give the PPO premium on the Plan C or D page, and the POS premium on the POS page.

F. The survey no longer requests information on premium guarantee periods.

Part 4

PREMIUM SURVEY

PLAN A

SEH PROGRAM PREMIUM COMPARISON SURVEY

PLAN A PREMIUM 1/1/\_\_\_\_

Carrier:	
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	Standard Premium
Bergen	
\$250	
Camden	
\$250	
Middlesex	
\$250	

--	--

PLAN B  
 SEH PROGRAM PREMIUM COMPARISON SURVEY  
 PLAN B PREMIUM 1/1/\_\_\_\_

Carrier:	
----------	--

	Standard Premium
Bergen	
\$250	
\$500	
\$1,000	
\$2,000	
Camden	
\$250	
\$500	
\$1,000	
\$2,000	
Middlesex	
\$250	
\$500	
\$1,000	
\$2,000	

Type of Plan: Indemnity, PPO, POS	
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Note change from \$2,500 to \$2,000 Deductible

PLAN C  
 SEH PROGRAM PREMIUM COMPARISON SURVEY  
 PLAN C PREMIUM 1/1/\_\_\_\_

Carrier:	
----------	--

	Standard Premium
Bergen	
\$250	
\$500	
\$1,000	
\$2,000	
Camden	
\$250	
\$500	
\$1,000	
\$2,000	
Middlesex	
\$250	
\$500	
\$1,000	
\$2,000	

Type of Plan: Indemnity, PPO, POS	
-----------------------------------	--

Note change from \$2,500 to \$2,000 Deductible

PLAN D  
 SEH PROGRAM PREMIUM COMPARISON SURVEY  
 PLAN D PREMIUM 1/1/ \_\_\_\_\_

Carrier:	
----------	--

	Standard Premium
Bergen	
\$250	
\$500	
\$1,000	
\$2,000	
Camden	
\$250	
\$500	
\$1,000	
\$2,000	
Middlesex	
\$250	
\$500	
\$1,000	
\$2,000	

Type of Plan: Indemnity, PPO, POS	
-----------------------------------	--

Note change from \$2,500 to \$2,000 Deductible

PLAN E  
 SEH PROGRAM PREMIUM COMPARISON SURVEY  
 PLAN E PREMIUM 1/1/ \_\_\_\_\_

Carrier:	
----------	--

	Standard Premium
Bergen	
\$150	
Camden	
\$150	
Middlesex	
\$150	

Type of Plan: Indemnity, PPO, POS	
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Specify deductible if Plan E is offered as PPO or POS with a deductible different from \$150

HMO PLAN  
 SEH PROGRAM PREMIUM COMPARISON SURVEY  
 HMO PLAN PREMIUM 1/1/ \_\_\_\_\_

Carrier:	
----------	--

	Standard Premium
Bergen	
\$15	

\$20	
\$30	
Camden	
\$15	
\$20	
\$30	
Middlesex	
\$15	
\$20	
\$30	

Assume \$0 Deductible, 100% Coinsurance

--	--

HMO/POS or POS PLAN  
 SEH PROGRAM PREMIUM COMPARISON SURVEY  
 POS PLAN PREMIUM 1/1/ \_\_\_\_

Carrier:	
----------	--

	Standard Premium
Bergen	
\$15	
\$20	
\$30	
Camden	
\$15	
\$20	
\$30	
Middlesex	
\$15	
\$20	
\$30	

Assume \$0 Deductible, 100% Coinsurance in, \$500 Deductible, Plan C or D Coinsurance OON

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**DELIVERY SYSTEMS (Plans A through E and HMO/POS or POS)**

Indicate below the Delivery System used for the Plans used in answering the survey. For example, if the rates provided for Plan D are for a PPO, then complete the columns labeled "PPO" for that plan and leave the columns labeled "Traditional" and "POS" blank. Use a similar method for a Plan that is a POS. If the rates provided are not for POS or PPO plans, check the appropriate space under the column labeled "Traditional" and leave the "PPO" and "POS" columns blank. Check "Yes" under "Other Delivery Systems" if more than one delivery system is available; otherwise check "No."

	Traditional	PPO			POS			Other Delivery Systems Available	
		Coinsurance		Copay	Coinsurance		Copay	Yes	No
		% In	% Out	\$	% In	% Out	\$		
Plan A									
Plan B									
Plan C									
Plan D									
Plan E									
POS									
Plan C									
Plan D									

\*Coinsurance percentages for Plan A are established by rule - no variations are permitted. See Exhibit A of Appendix to N.J.A.C. 11:21.

**Sample Tiered Premiums**

Carriers should submit additional information about the premium for the following plans of benefits in Middlesex County: a) \$1000 Deductible Plan C PPO; b) \$20 Copay HMO; and c) \$500 Deductible, \$20 Copay Plan C POS. For these plans only, the carrier should provide a detailed calculation of the premium shown in the PCS in the same format as the sample calculation in the Carrier's SEH rating filing pursuant to N.J.A.C. 11:21-9.1 et seq. the detailed calculations should be attached to this survey.

The results of this detailed calculation should be summarized in a table:

PLAN	Single	2 Adult	P.C	Family
\$1000C PPO				
\$20 HMO				
\$20/\$500C POS				

BbschbpnewFF/inoregs

New Rule, R.1995 d.289, effective June 5, 1995.  
 See: 27 N.J.R. 1127(b), 27 N.J.R. 2233(a).  
 Administrative correction.  
 See: 30 N.J.R. 1047(a).  
 Repeal and New Rule, R.1998 d.533, effective November 16, 1998.  
 See: 30 N.J.R. 2978(a), 30 N.J.R. 4045(a).

Section was "SEH Program Premium Comparison Survey".  
 Repeal and New Rule, R.2009 d.277, effective September 21, 2009.  
 See: 41 N.J.R. 1147(a), 41 N.J.R. 3451(a).  
 Exhibit was "SEH Program Premium Comparison Survey".