EXHIBIT BB

PART 1

CERTIFICATION OF COMPLIANCE WITH SMALL EMPLOYER HEALTH BENEFITS PLANS

In accordance with N.J.A.C. 11:21-4.2, submit this form, by March 1 of every year, to the SEH Board at the address specified at N.J.A.C. 11:21-1.3. Carriers must complete the certification as set forth in this Exhibit; the words in the certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name:_____ NAIC #:_____

Respondent Information:

Name: _____ Title: _____

Address:_____

_____

Telephone:_____ FAX:_____ Email address: _____

2. COMPLIANCE

Check the appropriate response(s).

_____(a) Plans A, B, C, D and E (both policies and certificates comply fully with the SEH Board's small employer health benefits plans forms and Explanation of Brackets set forth at Exhibits A, V, F, W and K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(c) The HMO Plan (both contract and evidence of coverage) complies fully with the SEH Board's small employer health benefits plans form and Explanation of Brackets set forth at Exhibit G, Y and K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(d) The HMO/POS plan (both contract and evidence of coverage) complies fully with the SEH Board's small employer health benefits plans form and Explanation of Brackets set forth at Exhibits HH, JJ and K, respectively, of the Appendix to N.J.A.C. 11:21,

and the HMO is in compliance with Department of Health and Senior Services regulations governing an HMO's ability to offer out-of-network services set forth at N.J.A.C. 8:38-14.

_____(e) All standard riders applicable to Plans B through E , HMO and HMO-POS comply fully with the SEH Board's small employer health benefits plan rider forms and Explanation of Brackets as set forth in Exhibits H and Exhibit K, respectively, of the Appendix to N.J.A.C. 11:21.

_____(g) All applications, certifications, and waiver forms, comply fully with the SEH Board's forms and the explanation of Brackets as set forth in Exhibits N, O, T, and K, respectively, of the Appendix to N.J.A.C. 11:21.

3. PLAN OPTIONS AND VARIABLES

Complete each relevant section. Attach additional pages as necessary.

(a) Plans A through E

On the attached worksheet for Plans A through E, provide information regarding all of the plans carrier makes available using Plans A through E. Add or delete rows under each plan designation, and provide all applicable information regarding each offering of each plan. Refer to N.J.A.C. 11:21-3.1 for information regarding permissible options.

Delivery System: Identify whether each plan is sold as Traditional Indemnity (Designate as Indem), Preferred Provider Organization (Designate as PPO); or Point of Service (Designate as POS).

Copayment: For all plans that use a copayment, specify the applicable copayments for Physician Visits, Maternity and Emergency Room. Note: All plans, regardless of delivery system, must specify the level of Emergency Room Copayment.

Deductible: List the available deductible options as specific amounts, not as a ranges. Indemnity plans as well as PPO and POS plans that use a common deductible should list that amount under the Indemnity/Common column. PPO and POS plans that use separate deductibles for network and non-network services should list such amounts under the appropriate column headings. Under Family Deductible/network indicate if the family deductible is 2 times or 3 times, and whether it must be satisfied on an individual or on an aggregate basis. For plans that use a separate deductible, specify the family deductible under the network and non-network columns. (Designate as 2X or 3X, indiv or aggr).

Coinsurance: List the available coinsurance options as specific percentages, not as a ranges. Indemnity plans as well as PPO and POS plans that use a common coinsurance should list that amount under the Indemnity/Common column. PPO and POS plans that use separate coinsurance for network and non-network services should list such percentages under the appropriate column headings.

Maximum Out of Pocket ("MOOP"): List the available maximum out of pocket as specific amounts, not as a ranges. Indemnity plans as well as PPO and POS plans that use a common maximum out of pocket should list that amount under the Indemnity/Common

column. PPO and POS plans that use a separate maximum out of pocket for network and non-network services should list such amounts under the appropriate column headings. . Under Family MOOP/network indicate if the family maximum out of pocket is 2 times or 3 times, and whether it must be satisfied on an individual or on an aggregate basis. For plans that use a separate MOOP, specify the family MOOP under the network and non-network columns. (Designate as 2X or 3X, indiv or aggr).

1. Do contracts provide for direct payment to health care practitioners without assignment? ☐ Yes ☐ No
2. Do the participation requirements comply with applicable statute and rules? (See N.J.S.A. 17B:27A-24 and N.J.A.C. 11:21-7.6)

☐ Yes ☐ No

If No, has the Board approved the carrier's use of an alternate participation requirements? ☐ Yes ☐ No

3. Do the plans include any of the following as set as variable text in the standard plans?

Yes	No	
☐	☐	Utilization Review Features
☐	☐	Required Hospital Stay Review
☐	☐	Required Pre-surgical Review
☐	☐	Specialty Case Management
☐	☐	Centers of Excellence Features
☐	☐	Appeal Procedures
☐	☐	Active Work requirement for non-health status related factors
☐	☐	Pre-existing conditions exclusion

4. Specify how coverage for autologous bone marrow transplants is offered.

Plan A selection: ☐ Plan benefit; or ☐ Rider benefit

Plans B through E selection: ☐ Plan benefit; or ☐ Rider benefit

5. Are the plans available through a multiple employer trust (MET)? ☐ Yes ☐ No If yes, complete the following:
Name and address of trustee:

_____

_____

Name of Settlor: _____ Contract State: _____

6. Are Plans C or D being offered as the non-network coverage of a Dual Contract HMO/POS Plan? ☐ Yes ☐ No

7. Is the standard prescription drug rider (Exhibit H) being made available? ☐ Yes ☐ No If yes, complete the Prescription Drug Rider section of this Certification with respect to each variation of the rider.

(b) HMO and HMO-POS Plans

On the attached worksheet for HMO Plans, provide information regarding all of the plans carrier makes available using the HMO and HMO-POS plans. Add or delete rows under each plan type, and provide all applicable information regarding each offering of each plan. Refer to N.J.A.C. 11:21-3.1 for information regarding permissible options.
Plan Type: Specify all options carrier makes available for the HMO plan as well as all options, if any, the carrier makes available for the HMO-POS plan.
Copayment: Specify the applicable copayments for Physician Visits, Maternity and Emergency Room.
Deductible: List the available deductible options as specific amounts, not as a ranges. POS plans that use a common deductible should list that amount under the Common column. POS plans that use separate deductibles for network and non-network services should list such amounts under the appropriate column headings. Under Family Deductible/network indicate if the family deductible is 2 times or 3 times, and whether it must be satisfied on an individual or on an aggregate basis. For plans that use a separate deductible, specify the family deductible under the network and non-network columns. (Designate as 2X or 3X, indiv or aggr).
Coinsurance: List the available coinsurance options as specific percentages, not as a ranges. POS plans that use a common coinsurance should list that amount under the Common column. POS plans that use separate coinsurance for network and non-network services should list such percentages under the appropriate column headings.
Maximum Out of Pocket: List the available maximum out of pocket as specific amounts, not as a ranges. POS plans that use a common maximum out of pocket should list that amount under the Common column. POS plans that use a separate maximum out of pocket for network and non-network services should list such amounts under the appropriate column headings. . Under Family MOOP/network indicate if the family maximum out of pocket is 2 times or 3 times, and whether it must be satisfied on an individual or on an aggregate basis. For plans that use a separate MOOP, specify the family MOOP under the network and non-network columns. (Designate as 2X or 3X, indiv or aggr).
Prescription Drugs: For HMO plans indicate whether prescription drugs are covered subject to 50% coinsurance or a $15 copayment. (Designate as 50% or 15)

1. Do the participation requirements comply with applicable statute and rules? (See N.J.S.A. 17B:27A-24 and N.J.A.C. 11:21-7.6)

☐ Yes ☐ No

If No, has the Board approved the carrier's use of an alternate participation requirements? ☐ Yes ☐ No

2. Do the plans include any of the following as set as variable text in the standard plans?

Yes	No	
☐	☐	Active Work requirement for non-health status related factors
☐	☐	Pre-existing conditions exclusion

3. Specify how coverage for autologous bone marrow transplants is offered.

HMO selection: ☐ Plan benefit; or ☐ Rider benefit

HMO-POS selection: ☐ Plan benefit; or ☐ Rider benefit

4. Is the HMO plan being used as network coverage of a Dual Contract HMO/POS Plan? ☐ Yes ☐ No

5. Is the standard prescription drug rider (Exhibit H) being made available? ☐ Yes ☐ No If yes, complete the Prescription Drug Rider section of this Certification with respect to each variation of the rider.

(c) Prescription Drug Rider

☐ Mail/Retail ☐ Retail Only ☐ Mail Only

_________ Generic Copayment

_________ Brand Copayment

_________ Preferred Brand Copayment

_________ Non-Preferred Brand Copayment

Is pre-approval required? ☐ Yes ☐ No

Available with plans : ________________________________

☐ Mail/Retail ☐ Retail Only ☐ Mail Only

_________ Generic Copayment

_________ Brand Copayment

_________ Preferred Brand Copayment

_________ Non-Preferred Brand Copayment

Is pre-approval required? ☐ Yes ☐ No

Available with plans : ________________________________

☐ Mail/Retail ☐ Retail Only ☐ Mail Only

_________ Generic Copayment

_________ Brand Copayment

_________ Preferred Brand Copayment

_________ Non-Preferred Brand Copayment

Is pre-approval required? ☐ Yes ☐ No

Available with plans : ________________________________

☐ Mail/Retail ☐ Retail Only ☐ Mail Only

_________ Generic Copayment

_________ Brand Copayment

_________ Preferred Brand Copayment

_________ Non-Preferred Brand Copayment

Is pre-approval required? ☐ Yes ☐ No

Available with plans : ________________________________

Note: Exhibit BB Part 6, which addresses the availability of optional benefit riders, must be completed by **all** carriers, whether or not optional benefit riders have been filed.

4. CERTIFICATION

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

I certify that any stop loss or excess risk insurance issued or renewed by the carrier meets the retention limits set forth in the definition of “stop loss” or “excess risk insurance” as defined at N.J.S.A. 17B:27A-17.

_____	_____
Signature	Title
_____	_____
Printed Name	Date

Carrier Name: _____

Plans A through E

Plan	Delivery System	Copayment			Deductible			Family Deductible		Coinsurance			Maximum Out of Pocket (MOOP)			Family MOOP	
		Physician Visit	Maternity	Emergency Room	Indemnity or Common	Network	Non-Network	Network	Non-Network	Indemnity	Network	Non-Network	Indemnity or Common	Network	Non-Network	Network	Non-Network
A																	
B																	
C																	
D																	
E																	

EXAMPLES

Plan	Delivery System	Copayment			Deductible			Family Deductible		Coinsurance			Maximum Out of Pocket (MOOP)			Family MOOP	
		Physician Visit	Maternity	Emergency Room	Indemnity or Common	Network	Non-Network	Network	Non-Network	Indemnity	Network	Non-Network	Indemnity or Common	Network	Non-Network	Network	Non-Network
C	indem			50	1000, 2500			2X indiv	2X indiv	70%			5000			2X indiv	2X indiv
C	PPO	15, 30	15, 30	50		1000, 250	2000, 5000	2X indiv	2X indiv		70%	100%		5000	10000	2X indiv	2X indiv
D	POS	30,50	30,50	50		1000, 250	2000, 5000	2X indiv	2X indiv		80%	100%		5000	15000	2X indiv	2Xindiv

Carrier Name _____

HMO and HMO-POS Plans

Plan Type	Copayment			Deductible			Family Deductible		Coinsurance			Maximum Out of Pocket (MOOP)			Family MOOP		Pescription
	Physician Visit	Maternity	Emergency Room	HMO or Common	Network	Non-Network	Network	Non-Network	HMO	Network	Non-Network	HMO or Common	Network	Non-Network	Network	Non-Network	
HMO																	
HMO-POS																	

EXAMPLES

Plan Type	Copayment			Deductible			Family Deductible		Coinsurance			Maximum Out of Pocket (MOOP)			Family MOOP		Pescription
	Physician Visit	Maternity	Emergency Room	HMO or Common	Network	Non-Network	Network	Non-Network	HMO	Network	Non-Network	HMO or Common	Network	Non-Network	Network	Non-Network	
HMO	15,20,30	15,20,30	75														50%
	30		75	2500			2X indiv		80%			5000			2X indiv		50%
HMO-POS	20,30	20,30	75	2500			2X indiv	2X indiv		100%	80%	5000			2X indiv	2X indiv	
	15, 20	15, 20	75		2500	5000	2X indiv	2X indiv		100%	70%		5000	15000	2Xindiv	2X indiv	

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

EXHIBIT BB

PART 6

USE OF
OPTIONAL BENEFIT RIDERS

In accordance with N.J.A.C. 11:21-3, submit this form, by March 1 of every year, to the SEH Board at the address specified at N.J.A.C. 11:21-1.3.

A. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name:_____ NAIC #:_____
If an HMO, is the Carrier federally qualified?
_____Yes _____No

Respondent's Name:_____

Respondent's Title:_____

Respondent's Address:_____

_____

Respondent's Telephone:_____FAX:_____

Respondent's Email:
_____

B. OPTIONAL BENEFIT RIDERS

1. Optional Benefit Riders of Increasing Value (N.J.A.C. 11:21-3.2)

Have you filed any optional benefit riders of increasing value that have been found to be complete and in substantial compliance by the SEH Board?

_____ Yes _____ No

If yes, please provide the following information for each optional benefit rider that has been filed with the SEH Board where the filing was determined to be complete and in substantial compliance with the requirements of N.J.A.C. 11:21-3.2. Attach additional sheets, as may be necessary. If no, skip to part B2.

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:

_____

b) Brief Description of the nature of the amendment:

_____

_____

c) Plan(s) with which the rider is available:

_____

d) If rider is no longer available, explain why:

_____

_____

e) Date the SEH Board found the rider to be complete and in substantial compliance:

_____

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:

_____

b) Brief Description of the nature of the amendment:

_____

_____

c) Plan(s) with which the rider is available:

_____

d) If rider is no longer available, explain why:

_____

_____

e) Date the SEH Board found the rider to be complete and in substantial compliance:

_____

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:

_____

b) Brief Description of the nature of the amendment:

_____

_____

c) Plan(s) with which the rider is available:

_____

d) If rider is no longer available, explain why:

_____

_____

e) Date the SEH Board found the rider to be complete and in substantial compliance:

_____

2. Optional Benefit Riders of Decreasing Value

Have you filed any optional benefit riders of decreasing value that have been approved by the Department of Banking and Insurance?

_____ Yes _____ No

If yes, please provide the following information for each optional benefit rider that has been filed with the Department of Banking and Insurance where the filing was approved. Attach additional sheets, as may be necessary. If no, skip to section C.

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:
_____

b) Brief Description of the nature of the amendment:
_____
_____

c) Plan(s) with which the rider is available:
_____

d) If rider is no longer available, explain why:
_____
_____

e) Date the Department of Banking and Insurance approved the rider
_____

Rider

a) Identifying Form Numbers of Policy/Contract Rider and corresponding Certificate/Evidence of Coverage Rider:
_____

b) Brief Description of the nature of the amendment:
_____
_____

c) Plan(s) with which the rider is available:
_____

d) If rider is no longer available, explain why:
_____
_____

e) Date the Department of Banking and Insurance approved the rider
_____

C. CERTIFICATION

I certify that the optional benefit riders identified above are the only riders to the standard health benefit plans issued by the carrier identified above which are not the standard riders adopted by the SEH Board.

I, the Undersigned, 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