

**STATE OF NEW JERSEY**

**Department of Banking and Insurance**

**SCA ANNUAL REPORT**

---

**Name of Carrier**

**December 31, 2008**  
**Year Ending**

**SCA ANNUAL REPORT**

---

Name of Carrier \_\_\_\_\_

---

**A. ADMINISTRATIVE INFORMATION**

**NAIC #:** \_\_\_\_\_ **TAX ID #:** \_\_\_\_\_

**Date Carrier Incorporated or Organized:** \_\_\_\_\_

**Date Carrier Commenced Business:** \_\_\_\_\_

**Date Carrier Certified as a SCA:** \_\_\_\_\_

**Statutory Home Office:** \_\_\_\_\_  
(Street) (City, State & Zip Code)

**Main Administrative Office:** \_\_\_\_\_  
(Street) (City, State & Zip Code)

**Contact Person:** \_\_\_\_\_  
(Name) (Area Code & Telephone Number)

\_\_\_\_\_  
(E-Mail) (FAX)

**CERTIFICATION BY OFFICER**

As an Officer of the carrier, I certify that for the reporting period stated above, all information and statements made in this Annual Report are true, complete and current to the best of my knowledge and belief.

---

Name \_\_\_\_\_ President \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

State of New Jersey  
Department of Banking and Insurance

**SCA ANNUAL REPORT**

---

Name of Carrier

---

**B. NETWORK INFORMATION**

Please identify the network used in the Selective Contracting Arrangement. If there is no SCA, please mark N/A. Designate whether the network is provided through an ODS, PPO in the case of a Prescription Drug Benefit, or through a direct contract with providers. Identify the principal contact person.

**I Hospital/Medical Network:** \_\_\_\_\_  
(Name of Network)

\_\_\_\_ Certified ODS    \_\_\_\_ Licensed ODS    \_\_\_\_ Direct Contract

Contact Person: \_\_\_\_\_, \_\_\_\_\_  
(Name) (Area code & Telephone Number)  
\_\_\_\_\_, \_\_\_\_\_  
(E-mail) (Fax)

**II Dental Network:** \_\_\_\_\_  
(Name of network)

\_\_\_\_ Certified ODS    \_\_\_\_ Licensed ODS    \_\_\_\_ Direct Contract

Contact Person: \_\_\_\_\_, \_\_\_\_\_  
(Name) (Area code & Telephone Number)  
\_\_\_\_\_, \_\_\_\_\_  
(E-mail) (Fax)

**III Vision:** \_\_\_\_\_  
(Name of network)

\_\_\_\_ Certified ODS    \_\_\_\_ Licensed ODS    \_\_\_\_ Direct Contract

Contact Person: \_\_\_\_\_, \_\_\_\_\_  
(Name) (Area code & Telephone Number)  
\_\_\_\_\_, \_\_\_\_\_  
(E-mail) (Fax)

**IV Prescription Drug Benefit:** \_\_\_\_\_  
(Name of network)

\_\_\_\_ PPO    \_\_\_\_ Direct Contract

Contact Person: \_\_\_\_\_, \_\_\_\_\_  
(Name) (Area code & Telephone Number)  
\_\_\_\_\_, \_\_\_\_\_  
(E-mail) (Fax)

State of New Jersey  
Department of Banking and Insurance

**SCA ANNUAL REPORT**

---

Name of Carrier

---

**B. NETWORK INFORMATION - continued**

**V Laboratory Network:** \_\_\_\_\_

(Name of network)

\_\_\_\_ Certified ODS    \_\_\_\_ Licensed ODS    \_\_\_\_ Direct Contract

Contact Person: \_\_\_\_\_, \_\_\_\_\_

(Name)

(Area code & Telephone Number)

\_\_\_\_\_, \_\_\_\_\_

(E-mail)

(Fax)

**VI Home Health Network:** \_\_\_\_\_

(Name of network)

\_\_\_\_ Certified ODS    \_\_\_\_ Licensed ODS    \_\_\_\_ Direct Contract

Contact Person: \_\_\_\_\_, \_\_\_\_\_

(Name)

(Area code & Telephone Number)

\_\_\_\_\_, \_\_\_\_\_

(E-mail)

(Fax)

**VII Behavior Health Network (Mental Health and Substance Abuse):**

\_\_\_\_\_

(Name of network)

\_\_\_\_ Certified ODS    \_\_\_\_ Licensed ODS    \_\_\_\_ Direct Contract

Contact Person: \_\_\_\_\_, \_\_\_\_\_

(Name)

(Area code & Telephone Number)

\_\_\_\_\_, \_\_\_\_\_

(E-mail)

(Fax)

**VIII Other Network:** \_\_\_\_\_

(Name of network)

Contact Person: \_\_\_\_\_, \_\_\_\_\_

(Name)

(Area code & Telephone Number)

\_\_\_\_\_, \_\_\_\_\_

(E-mail)

(Fax)

State of New Jersey  
Department of Banking and Insurance

**SCA Annual Report**

Name of Carrier \_\_\_\_\_

**C. Membership**

1. Please provide Membership by Rating Status

**MEMBERSHIP BY RATING STATUS**

| YEAR ENDING   | December 31, 2008 | December 31, 2007 |
|---------------|-------------------|-------------------|
| SINGLE EES *  |                   |                   |
| EE & SPOUSE * |                   |                   |
| EE & CHILD *  |                   |                   |
| FAMILY *      |                   |                   |
| TOTAL         | 0                 | 0                 |

\* Indicate the number of **employees** that are enrolled in each category.

2. Please complete the table for the number of employer contracts by products:

**Number of Employer Contracts by Products**

| Year Ending | Hospital/<br>Medical* | Prescription | Vision | Dental | Total |
|-------------|-----------------------|--------------|--------|--------|-------|
| 2008        |                       |              |        |        | 0     |
| 2007        |                       |              |        |        | 0     |

\* Which may include prescription, vision dental on a non stand alone basis

**SCA ANNUAL SUPPLEMENT**

---

Name of Carrier

---

3. Please complete the Plan Experience table for the SCA Line of Business for the previous calendar and prior calendar year. If any products are stand-alone, complete a separate table.

**PLAN EXPERIENCE**

| Calendar Year                     | 2008 | 2007 |
|-----------------------------------|------|------|
| Premium                           |      |      |
| Incurred Claims<br>In Network     | \$   | \$   |
| Incurred Claims<br>Out of Network | \$   | \$   |
| # Of Claims<br>In Network         |      |      |
| # Of Claims<br>Out of Network     |      |      |

## SCA ANNUAL Report

Name of Carrier

1. Please provide Membership by County or by zip code (first three digits only) for the previous calendar year.  
(Complete a separate table for each PPO/HMO)

### Membership by County as of December 31, 2008

|                             | #<br>Single | #<br>Employee &<br>Spouse | #<br>Employee & Child | #<br>Family | Total<br>Employees |
|-----------------------------|-------------|---------------------------|-----------------------|-------------|--------------------|
| Atlantic                    |             |                           |                       | 0           |                    |
| Bergen                      |             |                           |                       | 0           |                    |
| Burlington                  |             |                           |                       | 0           |                    |
| Camden                      |             |                           |                       | 0           |                    |
| Cape May                    |             |                           |                       | 0           |                    |
| Cumberland                  |             |                           |                       | 0           |                    |
| Essex                       |             |                           |                       | 0           |                    |
| Gloucester                  |             |                           |                       | 0           |                    |
| Hudson                      |             |                           |                       | 0           |                    |
| Hunterdon                   |             |                           |                       | 0           |                    |
| Mercer                      |             |                           |                       | 0           |                    |
| Middlesex                   |             |                           |                       | 0           |                    |
| Monmouth                    |             |                           |                       | 0           |                    |
| Morris                      |             |                           |                       | 0           |                    |
| Ocean                       |             |                           |                       | 0           |                    |
| Passaic                     |             |                           |                       | 0           |                    |
| Salem                       |             |                           |                       | 0           |                    |
| Somerset                    |             |                           |                       | 0           |                    |
| Sussex                      |             |                           |                       | 0           |                    |
| Union                       |             |                           |                       | 0           |                    |
| Warren                      |             |                           |                       | 0           |                    |
| Out of State                |             |                           |                       | 0           |                    |
| Unknown                     |             |                           |                       | 0           |                    |
| TOTAL<br>Employees Enrolled | 0           | 0                         | 0                     | 0           |                    |

The use of twenty (20) three digit zip codes can be used as an alternative to counties. # Indicate the number of Employees that are enrolled in each category.

State of New Jersey  
Department of Banking and Insurance

**SCA ANNUAL SUPPLEMENT**

Name of Carrier \_\_\_\_\_

5. Subscribers and members by type of payment

1. Total member months for the year: \_\_\_\_\_

2. Average monthly change: \_\_\_\_\_

(Dec. 31 current year minus Dec. 31 prior year membership divided by 12)

| Type of Payment                              | Subscribers*<br>at<br>End of Year |                                       | Total Members**<br>at<br>Year End |
|--|-----------------------------------|---------------------------------------|-----------------------------------|
|  | Subscriber<br>Total               | Average<br>Members<br>Per Subscribers | Actual                            |
|  | (a)                               | (b)                                   | (c)                               |
| A. Group Contracts (Non-Government)          |                                   |                                       |                                   |
| 1. SEH Standard Group Plans (2-50 Employees) |                                   | #DIV/0!                               |                                   |
| 2. Non-Standard Plans (2-30 Employees)       |                                   | #DIV/0!                               |                                   |
| 3. Large Group                               |                                   | #DIV/0!                               |                                   |
| 4. Student***                                |                                   | #DIV/0!                               |                                   |
| B. Individual Contracts                      |                                   | #DIV/0!                               |                                   |
| C. Government Plans                          |                                   |                                       |                                   |
| 1. FEHBP                                     |                                   | #DIV/0!                               |                                   |
| 2 Other/Local                                |                                   | #DIV/0!                               |                                   |
|  |                                   | #DIV/0!                               |                                   |
| D. Medicare****                              |                                   | #DIV/0!                               |                                   |
| E. Other (Specify)*****                      |                                   | #DIV/0!                               |                                   |
| TOTAL  | 0                                 | #DIV/0!                               | 0                                 |

Notes:

\* Subscriber means, in the case of a group contract, an individual whose employment or other status, except family status, is the basis for eligibility for enrollment or, in the case of an individual contract, the person in whose name the contract is issued.

\*\* Total Member means the total number of covered persons.

\*\*\* Student means anyone who is covered under a Student Health Plan.

\*\*\*\* Medicare relates only to members enrolled in programs complementary to Title XVIII, or under direct cost contracts or risk contracts with the Social Security Administration. Excludes Medicare eligible in other categories.

\*\*\*\*\* COBRA extension, small group extensions, etc. not reported in other categories.