

**NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH
VALUATION BUREAU
POST OFFICE BOX 325
20 WEST STATE STREET
TRENTON, NEW JERSEY 08625**

**HEALTH MAINTENANCE ORGANIZATION (“HMO”) APPLICATION FOR A NEW
CERTIFICATE OF AUTHORITY**

OTHER THAN MEDICARE ONLY

INTRODUCTION

The information requested in this application is based upon the New Jersey Health Maintenance Organization Act (N.J.S.A. 26-2J-1, et seq.), regulations (N.J.A.C. 11:24-1, et seq.) and bulletins.

The applicant is expected to demonstrate that each licensing requirement is met. The Commissioner’s decision whether to grant a Certificate of Authority (“COA”) is based upon the analysis of the documents submitted. The application shall be deemed complete when all the required information is filed on forms and in the format prescribed by use, pursuant to the procedures described below.

INSTRUCTIONS

1. Four copies of the application must be submitted to:

NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH
VALUATION BUREAU

If Regular USPS Mail use

P.O. BOX 325
TRENTON, NEW JERSEY 08625-0325

If Overnight Service use

20 WEST STATE ST.
TRENTON, NEW JERSEY 08608-1206

If Medicaid services are involved, forward an additional copy of the application to:

NEW JERSEY DEPARTMENT OF HUMAN SERVICES (“DMAHS”)
OFFICE OF MANAGED HEALTH CARE
QUAKERBRIDGE PLAZA

P.O. BOX 712
TRENTON, NEW JERSEY 08625

2. A check or money order for \$100 payable to “State of New Jersey- General Treasury” is to accompany the application.
3. Complete the application Cover Sheet and provide all narratives and documents as described in the ensuing sections. The Cover Sheet must include an original signature by the President/CEO or other responsible officer of the HMO.
4. Number each narrative and document according to the number to which it corresponds, (e.g. II. Organization/Legal). Number each page consecutively in the upper right hand corner, throughout the filing. Tabs should be inserted indicating each of the six major sections of the application. All exhibits, charts, etc. should be in the appropriate section and placed in three-ring binders with the identifying information on the front and the spine.
5. If the applicant is offering HMO coverage to the Individual and Small Employer Groups (2-50 employees) market, provide a certification that the contracts, evidence of coverage forms and rates have been or shall be properly filed or certified pursuant to N.J.S.A. 17B:27A-1 et seq., N.J.A.C. 11:20 et seq., and N.J.A.C. 11:21-1 et seq.

**HEALTH MAINTENANCE ORGANIZATION
APPLICATION FOR A NEW CERTIFICATE OF AUTHORITY**

COVER SHEET

Name of Health Maintenance Organization

NAIC Number

FEIN Number

Address

City

County

State

Zip Code

Chief Executive Officer

Telephone Number

Fax Number

Email Address

Application Administrative Contact

Telephone Number

Fax Number

Email Address

Application Financial Contact

Telephone Number

Fax Number

Email Address

Plan offered or applied for: (check all that apply):

HMO Start up _____

Large Group (over 50) _____

Small Group (2-50) _____

Individual _____

Commercial _____

Medicaid _____

Medicare _____

Point-of Service _____

Open Access _____

Other _____ (Please describe in detail)

For-Profit _____

Not-For- Profit _____

Anticipated date of operation in New Jersey.

Proposed service area. List Counties.

Will a Federal Qualification be filed? Yes _____ No _____

Parent Company Name

Parent Contact Person

Parent Telephone Number

Fax Number

Parent Email Address

Guarantor (If different from Parent)

Guarantor Contact Person

Guarantor Telephone Number

Fax Number

Guarantor Email Address

I CERTIFY that all information and statements made in this application are true, complete and current to the best of my knowledge and belief.

Name and Title*

Original Signature

Date

*Must be President/CEO or other responsible senior officer.

I. General Description

1. Describe the HMO's origin and structure. Include a discussion of the parent and all affiliates and their current activities. Include a discussion of guarantor if other than parent or affiliate.
2. Initial applicants must provide a history of financial results over the last five years of the Capital and Surplus guarantor (GAAP audited Balance Sheet and Revenue and Expense Statement or 10K filing acceptable).
3. Include a mission statement and summary of a three year business plan.

II. Organizational/Legal

1. Provide a copy of the organizational documents (Articles of Incorporation, Partnership Agreements, Articles of Association, Management Agreements or other documents governing the operations applicable to the form of business of the HMO).
2. If not a New Jersey corporation, submit a copy of the HMO's certificate from the New Jersey Department of Treasury certifying the HMO is registered to do business in New Jersey. Submit copies of all changes to the Article of Incorporation, or similar, filed leading to the HMO's current name.
3. Provide a copy of the bylaws, rules or similar documents relating to the conduct of the internal affairs of the applicant.
4. Provide a list of owners of the HMO:
 - a. Include all owners with a 10% or greater ownership share;
 - b. List all non-owner investors, their level of investment and describe the structure of the investment.
5. Provide a list of the names, addresses, official positions and biographical affidavits (use NAIC Form 11, [Biographical Affidavit](#)) of persons responsible for the conduct of the affairs of the HMO, including but not limited to the board of directors, executive committee, or members of other governing board or committee; the principal officers or partners; shareholders owning or having the right to acquire 10% or more interest in the HMO; and the New Jersey Medical Director. Provide a statement of any criminal convictions and civil, regulatory or enforcement actions, including actions related to professional licensing, taken or pending.
6. Please depict the following charts:
 - a. All contractual arrangements of the health care delivery system;
 - b. Internal management and administrative staff of the HMO;

- c. Identify relationships between and among the applicant and all affiliates.
7. Provide a list of in-force insurance covering the HMO, including where applicable:
 - a. A cover-note or declaration page for stop loss insurance;
 - b. A complete fully executed policy for insolvency coverage to include at a minimum:
 - i. Continuation of coverage to end of premium paying period;
 - ii. Continuation of in-patient coverage to date of discharge;
 - c. A cover note or declaration page for malpractice for the HMO and employed providers.
8. Provide a copy of the approval of the Attorney General's office in the case of purchase and/or conversion from non-profit to for-profit status. Provide a detailed description of any charitable trust or similar organization established in relation to a conversion to for-profit status.
9. For an initial COA application, provide a copy of the Power of Attorney (attached) duly executed by the applicant, if not domiciled in this State, appointing the Commissioner and his or her successors in office, and duly authorized designees, as the true and lawful attorney of the applicant in and for this State upon whom all lawful process in any legal action or proceeding against the HMO on a cause of action arising in this State may be served.
10. Provide a specimen copy of provider contracts between each type of provider (e.g. physician, specialist, hospital, ancillary, etc.) and the HMO, including all referenced appendices and descriptions of any compensation program involving incentive or disincentive payment arrangements. Include all variants of contracts for a particular service provider.
11. Provide a copy of all contracts between the HMO and services being subcontracted including contracts with: Organized Delivery Systems, Pharmacy Benefit Managers, PPO and other entities providing health services to HMO members. Include a specimen copy of the contracts between all subcontracting entities and their individual participating providers. If the contracting party is a licensed or certified ODS and has already filed the forms with the Department, please submit a list of contracts submitted to the Department by the ODS including the form number and date of approval.
12. Provide copies of any contracts made or to be made between any persons listed in numbers 4 and 5 (above) and the HMO.
13. Provide copies of any contract made or to be made with an insurer, a medical or health service corporation, Third Party Administrator ("TPA") or other entity and the HMO for the provision of administrative, claims or management services.

14. Provide a description of the mechanism by which members and providers will be afforded the opportunity to participate in matters of policy and operation.
15. Provide a statement from an officer of the HMO attesting that it and all affiliated entities have been in compliance with all applicable State and Federal laws for the last 12 months.
16. Certify as to whether or not the applicant or any affiliates have ever been penalized by any State or Federal agency and/or have ever been under special financial supervision by a State or Federal agency. If penalized or otherwise sanctioned, please provide the details of such actions against the plan.

III. Health Care Services

1. **Designation of a medical director** – The HMO must designate a physician to serve as the medical director for medical services provided to the HMO’s New Jersey members. This physician must be licensed to practice medicine in New Jersey. The responsibilities of the medical director are delineated at N.J.A.C. 11:24-4.2. Identify the designated medical director and describe his/her functions. Please submit the following information:
 - a. Credentialing policies and procedures including verification of provider and facility credentials and querying recognized monitoring sources.
 - b. Procedures for maintaining oversight over any delegated credentialing activities.
 - c. Recredentialing policies and procedures which include coordination with continuous quality improvement, utilization management, and members services.
 - d. A description of the structure and functions of the committee responsible for reviewing applications submitted by providers applying for network participation.
 - e. Policies governing termination of providers, including notice requirements, continuity of care, and hearings for terminated providers.
2. **Provider Network:** The HMO shall maintain primary, specialty, ancillary and institutional services sufficient to serve the enrolled population at all times. The applicant must demonstrate compliance with the provider network standards at N.J.A.C. 11:24-6. Please submit the following:
 - a. A directory of providers by specialty and by county. Please include provider’s name, office address, phone number, specialty and hospital affiliation. Indicate whether board certified or board eligible.
 - b. A certification signed by an officer of the company attesting that all participating providers represented as such are licensed, credentialed, have the capacity and are willing to provide medical care to enrolled members.

c. Completed provider network tables, as identified below:

- i. [Summary of Physicians by County](#)
- ii. [Summary of Physicians by Region – North](#)
- iii. [Summary of Physicians by Region - Central](#)
- iv. [Summary of Physicians by Region – South](#)
- v. [General Acute Hospitals](#)
- vi. [Summary of Ancillary and Specialized Providers by County](#)

In completing the Summary of Physicians by Region, please note that the numbers and types of providers listed on these tables by county must correspond with the numbers and types of physicians listed in the directory. There should be at least two (2) physicians in every specialty in each county. If there are no specialists under contract in the county, members must be able to access such services in an adjacent county. Indicate the number of physicians from adjacent counties that will serve members of the county where specialists are missing. Submit a separate attachment identifying the physicians in the adjacent county and include the physician's address, city/town, county, telephone number, specialty, hospital affiliation and the county the specialist is supplementing.

d. A geo-access accessibility detailed summary report of PCPs, specialists and hospitals for each county based on the county's projected enrollment after one year. The report should demonstrate compliance with the provider network standards found at [N.J.A.C. 11:24-6](#). Also address the plan's standards for assuring that the numbers and types of providers keep pace with enrollment growth.

3. **Continuous Quality Improvement (CQI):** The HMO shall have a system-wide continuous quality improvement program to monitor the availability, accessibility, quality and appropriateness of care on an ongoing basis. The program must be under the direction of the medical director.

Submit a full description of the CQI plan which shall include at least the following:

- a. Policies and procedures demonstrating compliance with [N.J.A.C. 11:24-7 et seq.](#) including:
 - i. Specifications of standards of care, criteria and procedures for assessing the quality, adequacy and appropriateness of health care resources utilized.
 - ii. A system of ongoing evaluation activities including focused case reviews as well as pattern analysis.

- iii. A system of monitoring member and provider satisfaction and feedback.
 - iv. Procedures for conducting peer review.
 - v. A system to coordinate the CQI program with other performance monitoring activities, including UM, risk management, member and provider complaints programs.
 - vi. A system to monitor and evaluate the performance of subcontracted entities including Organized Delivery Systems (ODS), Pharmacy Benefit Managers and Laboratory Services.
 - vii. A system to evaluate the effectiveness of the CQI program.
- b. The structure and responsibilities of the multidisciplinary CQI Committee.
 - c. The involvement of the Board of Directors with the CQI program, including the mechanism by which the Board of Directors shall be apprised of all CQI activities.
4. **Utilization Management (UM):** The HMO shall have a comprehensive utilization management program to monitor access to and appropriate utilization of health care services.

Submit a full description of the UM program. The program must be under the direction of the medical director and include the following:

- a. Policies and procedures which demonstrate compliance with N.J.A.C. 11:24-8 et seq. including:
 - i. Procedures to evaluate medical necessity including written criteria and protocols used in decision making.
 - ii. Mechanisms to detect under utilization and over utilization.
 - iii. Mechanisms to ensure consistent application of review criteria and uniform decisions.
 - iv. Outcomes and process measures.
 - v. Mechanisms to evaluate member satisfaction with the complaint system and UM appeals system.
 - vi. Mechanisms for developing and updating clinical criteria and protocols with involvement from practicing physicians and other licensed health care providers within the network. Describe how clinical criteria and protocols are made readily available to members and providers.
 - vii. Responsibilities, qualifications and availability of staff that render UM determinations to authorize, deny and limit admissions, services, procedures or extensions of stay, availability pursuant to N.J.A.C. 11:24-8.2 et seq.
 - viii. UM appeal processes as set forth at N.J.A.C. 11:24-8.4 through 8.7.
5. **Member Rights** - Submit a description of the member services system which includes implementation of member rights in accordance with N.J.A.C. 11:24-9.1.
6. **Member Complaint and Appeal System** – The Plan shall maintain a system to provide for the presentation and resolution of complaints brought by members and

or providers acting on behalf of a member with the members consent, in accordance with N.J.A.C. 11:24-3.7(a).

- a. Submit policies and procedures demonstrating that the HMO's complaint system incorporates the following components:
 - i. Written notification to all members and providers of the telephone numbers and business addresses of the HMO employees responsible for complaint resolution.
 - ii. A system to record and document the status of all complaints.
 - iii. Demonstration of the availability of HMO member services representatives to assist members with complaint procedures.
 - iv. Establishment of a specified response time for complaints which does not exceed 30 days from the HMO's receipt of the complaint.
 - v. A process describing how complaints are processed and resolved.
 - vi. Procedures for follow-up action including methods used to inform the complainant of resolution.
 - vii. Procedures for notifying the CQI program of all valid complaints related to quality of care.
 - viii. The mechanism for notifying members and providers that they may contact the appropriate regulatory agency if dissatisfied with the resolution reached through the HMO's internal complaint system.
 - b. Submit specimens of the letters regarding complaint and complaint resolution to be sent to members and providers.
7. **Provider Complaint System** - Submit the Plan's policies and procedures that address the presentation and resolution of complaints brought by providers in accordance with N.J.A.C. 11:24-3.7(b).
8. **Emergency and Urgent Care** - Submit the Plan's policies and procedures that govern the provision of emergency and urgent care and demonstrate compliance with N.J.A.C. 11:24-5.3.

IV. Information System

1. Provide a description of the information system used to support quality improvement and utilization management.
 - a. Include a description of data systems used to collect and analyze performance measures. Please identify performance measurement system used (i.e. HEDIS),
 - b. Include a description of data systems used for clinical management and evaluation of clinical services.
2. Provide a description of the information systems used to support member services and member and provider complaint and appeal systems.
3. Provide a description of information systems used to credential and recredential providers.
4. Provide a description of the collection and use of encounter data. Include a copy of encounter forms used and listing of data elements collected.
5. Provide a description of the methods used to verify and improve data quality. Include descriptions of procedures used to monitor data element accuracy and reliability, to oversee data input, storage, and retrieval, and to access the completeness of data.
6. Provide a description of data security and confidentiality procedures.

V. Claims Systems

1. Provide an explanation of the system used to monitor the quality, accuracy, and timeliness of claim and capitation payments.
2. Describe the HMO's Open and Unreported (O&U) claim tracking system, Coordination of Benefits (COB) and reinsurance recouping systems.
3. Provide a description of how claims are tracked for timely payment in accordance with N.J.S.A. 26:2J-8.1 and associated agreements, if any, and how interest is determined if payments to providers or subscribers are late. How does a provider "prove" when a claim was submitted? Please demonstrate how the HMO is in compliance with N.J.A.C. 11:22, et seq.
4. If applicable, provide a description of how the HMO will subrogate against a third party.

5. If claims are being processed by a third party, submit the contract establishing the responsibilities of all parties. Is the party a licensed or registered TPA as required by N.J.S.A. 17B:27B-1, et seq.?
6. Provide a summary of the HMO's claims policies, procedures and guidelines.
7. How will the HMO ensure compliance with New Jersey statutes and regulations regarding prompt pay, unfair claim practice laws, etc.?
8. Describe the HMO's Claims Department proposed interaction with the Actuarial Department and the Underwriting Department.
9. Provide the process for the ongoing identification of new and emerging risks related to the claims activities.
10. Provide the process for the management of claim risks.
11. Based on the HMO's previous experience in managing risk, identify the risks that historically have been the most significant and how they were managed.
12. Describe the process by which the Claims Departments will report to the Board of Directors and the Audit Committee.
13. Identify the key members within the Company who will be responsible for risk management.

VI. Marketing

1. Provide a description of significant service area demographics by county (overall population figures, age/sex mix, social/demographic factors, etc.) which will affect enrollment. Separate for commercial, Medicare and Medicaid.
2. Comment on the effect of competition among the two or three largest HMO's in the proposed counties and the applicant in terms of benefits, rates, and market penetration.
3. Provide a description of the HMO's marketing strategy including, but not limited to, use of agents, sales representatives, brokers, salaried employees or other distribution systems. Include the organizational structure for marketing. Separate individual, small group, large group, Medicare and Medicaid. Include any underwriting guidelines the HMO proposes to use in the large group market.
4. Describe the system for monitoring, marketing, and projections of marketing staff to assure ethical professional marketing behavior of agents.

5. Provide a breakdown of the HMO’s marketing budget separating commercial, Medicare and Medicaid as follows:

a. Salaries	\$ _____	\$ _____	\$ _____
b. Administration/other	\$ _____	\$ _____	\$ _____
c. Advertising/PR	\$ _____	\$ _____	\$ _____
d. Commissions	\$ _____	\$ _____	\$ _____
e. Total marketing			
Budget	\$ _____	\$ _____	\$ _____
f. Total Administrative			
Budget	\$ _____	\$ _____	\$ _____

6. Provide enrollment projections by county on a monthly basis for the first year of operation. These projections should be separated by line of business and must be accompanied by realistic, specific assumptions. The projections shall be broken out by male/female, under age 18, 19-64, and 65 and over.

VII. Financial

1. Provide the most recently audited financial statements of the HMO (statutory basis, GAAP basis is acceptable if no statutory audit) and parent (or affiliate if it is to be the Capital and Surplus Guarantor) with the internal control letter prepared by the independent CPA. (N.J.A.C. 11:24-11.6(b)3).
2. Provide the most recent unaudited financial statements of the HMO and parent (or affiliate).
3. Provide quarterly projections for the HMO up to the year following “break even” but not less than three years in total. The projections shall include:
 - Proforma Balance Sheet, Income Statement, Statement of Cash Flows, and enrollment data. The Income Statement and enrollment data shall be segregated and subtotaled by Commercial, Medicare, and Medicaid lines of business if applicable.
 - Calculation of the Medical Loss Ratio (MLR), Administrative Expense Ratio (AER) and IBNR.
 - Calculation of the Minimum Net Worth required pursuant to (N.J.A.C. 11:24-11.1(b)) and Risk Based Capital (RBC) required pursuant to (N.J.A.C. 11:2-39), with a demonstration that the HMO will meet the greater of the Minimum Net Worth requirement and the RBC requirement. Please note that the RBC requirement effectively eliminates the phase in provision found at N.J.A.C. 11:24-11.1(b) 4. (not required for foreign HMOs)
 - Cost of a financial condition examination performed every three to five years. The Department defers to the State of domicile for foreign HMOs.
 - The proposed financial terms and conditions for all anticipated subcontracting arrangements (see Addendum, item 14).

- Expansion applications: the projections must include “with expansion” and “without expansion” projections.
 - Assumptions explaining every line item of the projections, i.e., MLR, AER, IBNR, etc.
 - Foreign HMOs: provide New Jersey counties.
4. The source of the initial capital to support the plan to “breakeven” must be identified. (N.J.A.C. 11:24-11.1(b)4).
 5. Provide the investment strategy in sufficient detail to demonstrate compliance with the 60% liquidity requirement set forth at N.J.A.C. 11:24-11.1(c) (not required for foreign HMOs).
 6. All investments must be in accordance with the investment requirements set forth at N.J.S.A. 17B:20-1, et seq.
 7. Provide a signed copy of the attached Capital and Surplus Guaranty with the accompanying Board of Directors resolution. A guarantor must meet the requirements of N.J.A.C. 11:24-11.1(d).
 8. Demonstrate that the HMO shall meet the minimum solvency requirements for administrative expenses (20% of minimum net worth requirement between \$300K and \$1,000K adjusted annually by CPI) (N.J.A.C. 11:24-11.4 a, b). As of June 30, 2011 the minimum is \$528K and the maximum is \$1,759K. (Please check with the Department as these requirements are subject to change.)
 9. Demonstrate that the HMO shall meet the insolvency deposit for claims per N.J.A.C. 11:24-11.4(d). The calculation is 50 percent of the highest calendar quarterly premium for the preceding calendar year. (Note the two year phase in for HMOs.) Foreign HMOs: based on New Jersey premiums only.
 10. Describe in a one page summary the HMOs Financial Management Information System.
 11. Provide a plan for continuation of services upon the declaration of insolvency (N.J.A.C. 11:24-11.5).

ADDENDUM

Upon approval of the application and issuance of the Certificate of Authority, the policy forms and rate filings must be filed with the Department. Please refer to [Bulletin No. 09-05](#) for the policy forms and rates filing procedures.

The following is a list of requirements for all licensed HMO's.

1. New Jersey domestic HMOs are subject to the NJ Corporate Business Tax. The Department defers to the State of domicile for foreign HMOs.
2. HMOs are assessed 2% of their Commercial and Medicaid direct written premium in New Jersey on a quarterly basis.
3. HMOs are assessed \$1.50 per Commercial member for premium written in New Jersey
4. HMOs must submit a business plan if their minimum net worth calculation is less than 125% of the minimum requirement (N.J.A.C. 11:24-11.6(f)) or between 150% and 200% of the RBC requirement (N.J.A.C. 11:2-39) or between 200% and 300% and the Combined Ratio is .105% per the NAIC Model Act.
5. HMOs must file quarterly actuarial certifications. (not applicable to foreign HMOs)
6. HMOs must provide a rate filing for each large group product.
7. HMOs must file a plan for continuation of services upon the declaration of insolvency. (N.J.A.C. 11:24-11.5)
8. HMOs must file in accordance with the Holding Company Act. (N.J.S.A. 17:27A). (note 1/3 Board Of Directors rule and 100% independent committee)
9. HMOs are required to have a financial condition examination performed every three to five years with the cost borne by the HMO. (N.J.S.A. 26:2J-18.1) Include in the projections and footnote. Foreign HMOs: the Department defers to the State of domicile.
10. HMOs must file quarterly the NAIC Health Blank on a SAP basis in accordance with the NAIC Accounting Practices and Procedures Manual. (N.J.A.C. 11:24-11.6)
11. HMOs must file Annual Financial Statements by March 1st of each year pursuant to N.J.S.A. 26:2J-9.
12. HMOs must file an Annual Supplement as required by N.J.A.C. 11:24-3.8(a) 2.

13. Provide the most current Financial Condition Examination and Market Conduct Examination performed by a Regulatory Agency.
14. Provide the proposed financial terms and conditions for all anticipated subcontracting arrangements, i.e. Reinsurance, Stop Loss, Insolvency Protection, Pharmaceutical, Vision, Dental, Behavioral Health, Cardiovascular, etc. Include in the projections and footnote.

Appointment of Attorney for the State of New Jersey

KNOW ALL MEN BY THESE PRESENTS: That the _____
(the "COMPANY") of the County of _____ in the State of
_____, desiring to do business in the State of New Jersey
in conformity with the laws thereof, hereby, constitutes and appoints the Commissioner of
Banking and Insurance of New Jersey, and his or her successor in office, to be its true and
lawful Attorney, upon whom all original process in any action or legal proceeding against
said COMPANY may be served. And the said COMPANY hereby stipulates and agrees that
any original process against it, which is served upon said Attorney, shall be of the same legal
force and validity as if served upon said COMPANY, and that the authority of said Attorney
shall continue in force irrevocable so long as any liability of said COMPANY remains out-
standing in New Jersey.

IN WITNESS WHEREOF, the said COMPANY has caused these presents to be sub-
scribed by its President, and attested by its Secretary, and its corporate seal to be hereunto af-
fixed, this _____ day of _____ 20_____.

(Corporate Seal--if applicable)

President (or authorized representative)

(Print or Type Name)

Attest:

Secretary (or authorized representative)

(Print or Type Name)

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

CAPITAL AND SURPLUS GUARANTY

This Guaranty is made on this _____ day of _____ 20____, by _____(hereafter “Guarantor”) a corporation formed under the laws of (name of domiciliary jurisdiction) _____.

Whereas, Guarantor is or will be in control of _____(hereafter “Licensee”) as that term is defined at N.J.S.A.17:27A-1c,

Whereas, on the date of this Guaranty, Licensee has an existing Certificate of Authority with the Commissioner of Banking and Insurance, of the State of New Jersey, to do the business of a Health Maintenance Organization in the State of New Jersey;

Whereas, Guarantor desires that the Commissioner of Banking and Insurance, of the State of New Jersey, exercise his/her discretion to and continue to grant a Certificate of Authority to Licensee to do the business of a Health Maintenance Organization in the State of New Jersey, and makes this resolution as a condition of maintaining approval for the Certificate of Authority; and

Whereas, Guarantor desires to give legal assurances to the Commissioner of Banking and Insurance, of the State of New Jersey, that at all times its control of the Licensee will be or will have been exercised so that Licensee’s general surplus meets or exceeds the requirements of the State of New Jersey, as amended at any time.

Wherefore, Guarantor absolutely and unconditionally guarantees as follows:

1. Licensee shall have and maintain general surplus at least in the minimum amount as required by law, and such additional surplus as the Commissioner of Banking and Insurance, of the State of New Jersey, requires so that its surplus as regards enrollees is reasonable in relation to Licensee’s outstanding liabilities and financial needs as to all of its obligations including its obligations to New Jersey enrollees.
2. Licensee shall have and maintain this general surplus in funds and investments which are admitted assets under the investment laws governing Health Maintenance Organizations in the State of New Jersey.
3. Licensee shall have and maintain adequate general surplus as herein contemplated so long as Licensee has any Health Maintenance Organization obligations to enrollees in the State of New Jersey.

4. This Guaranty shall continue until such time as the Commissioner of Banking and Insurance, of the State of New Jersey, may release Guarantor in writing.
5. This Guaranty is made in addition to all other requirements and obligations imposed on Guarantor and Licensee by New Jersey law.
6. The Commissioner of Banking and Insurance of the State of New Jersey may enforce this Guaranty as an alternative to or, in addition to any other remedies provided by New Jersey law, by making a written demand upon Guarantor to deposit funds into the account of Licensee currently held pursuant to N.J.A.C. 11:24-11.4(d)1.
7. The Commissioner of Banking and Insurance of the State of New Jersey may enforce this Guaranty in his/her capacity as Commissioner of Banking and Insurance or in any other capacity provided by law whether as Supervisor, Rehabilitator, Liquidator, Ancillary Receiver, Conservator, or any other capacity.
8. Guarantor consents to the exclusive jurisdiction of the Superior Court of New Jersey, Mercer County for enforcement of this Guaranty and all other purposes related to this Guaranty.
9. Guarantor waives all defenses related to the capacity of and authority of any person concerning the making of this Guaranty, whether the defense is based on the law of New Jersey, or any other jurisdiction.
10. This Guaranty may be amended only in writing signed by the Commissioner of Banking and Insurance of the State of New Jersey and Guarantor.
11. Except as herein stated, this Guaranty cannot be enforced by any third party.
12. Guarantor warrants that it has the capacity to and is authorized to make this Guaranty. Attached hereto and made a part hereof is a Certified Resolution of the Board of Directors of Guarantor authorizing the making of this Guaranty.
13. Guarantor authorizes the Commissioner of Banking and Insurance of the State of New Jersey to hold this Guaranty in the records of the New Jersey Department of Banking and Insurance as a public document not subject to any requirement, now or hereafter pertaining, that it is or should be treated as confidential.
14. Guarantor agrees that within 15 days following receipt of a written demand of the Commissioner of Banking and Insurance of the State of New Jersey, because the general surplus has dropped below 125% of the minimum requirement established by law or because the Commissioner has otherwise reasonably determined that the surplus of the licensee is insufficient in respect to its outstanding liabilities and financial needs as to all of its obligations, including its obligations to New Jersey enrollees, Guarantor will deliver to a depository or custodian located in New Jersey sufficient funds or other assets satisfactory to the Commissioner of Banking and Insurance of the State

of New Jersey to meet its obligations under this Guaranty. Further, Guarantor shall notify any issuer or maker of any such assets, which are investment securities, that it has so-delivered such assets under this Guaranty.

Guarantor's contract with any such depository or custodian shall refer to this Guaranty and shall permit withdrawal of such funds or other assets only upon prior written approval or prior written demand of the Commissioner of Banking and Insurance of the State of New Jersey and any such withdrawal shall be made only for purposes of meeting the obligations of this Guaranty or for such other purpose as the Commissioner of Banking and Insurance may permit in writing.

Guarantor agrees that the delivery of such funds or other assets to a depository or custodian under this Guaranty constitutes, for all purposes of law, possession of such funds or other assets by the Commissioner of Banking and Insurance, of the State of New Jersey, whether title to such funds or other assets remains in Guarantor or otherwise as required by the Commissioner of Banking and Insurance of the State of New Jersey.

15. Demand and notice of obligations under this Guaranty are hereby waived by Guarantor, and Guarantor acknowledges that Guarantor's liability is absolute and unconditional and not dependent on the pursuit of any other remedies or on the exercise of any authority against the Licensee or any other person.

16. Other than the obligations stated in this Guaranty, there are no oral or written prior or contemporaneous agreements between Guarantor and the Commissioner of Banking and Insurance of the State of New Jersey, or between the Licensee and the Commissioner of Banking and Insurance, of the State of New Jersey.

Signed at _____ on the _____ day of _____, 20____.

Guarantor: _____

By: _____

Its: _____

Attachment Required: Board Resolution, see paragraph 12